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ABSTRACT

This guide is intended to assist Wisconsin school districts in accessing the health care financing system as a means of supporting specialized services. Topics covered include: determination of a local education agency's potential for third-party covered services; the need to become a certified provider dependent upon the funding source; determination of whether local education agency staff meet the qualifications necessary to become a certified provider; establishment of a system or mechanism to document relevant treatment-services data and translate that data into an appropriate third-party claim; and obtaining parental consent. Individual chapters address the following areas: (1) historical background--legal basis for third-party claims; (2) cautions in accessing third-party funds and gaining parental support; (3) delivery of health care services in an educational setting; (4) the Wisconsin Medical Assistance Program coverage of medically necessary services provided in the schools; (5) the health care financing system (including military coverage, state programs, private commercial plans, funded plans, and managed care alternatives); (6) documentation; (7) collection and transmission of treatment data; (8) insurance claim form preparation; (9) the life cycle of an insurance claim; (10) reporting third-party reimbursements; and (11) the "make or buy" decision. Extensive appendixes provide sample forms and documentation. A glossary and list of 11 state resources are also included. (DB)

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Accessing The Health Care Financing System:

A Resource Guide

for Local Education Agencies

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Introduction

The Department of Public Instruction recognizes that state and local school administrators, legislators, and school boards are concerned about how to maintain and improve quality services to students in an effective and fiscally responsible manner. To assist local districts, the Department offers this manual as a resource guide to aid and encourage school districts to explore the option of accessing the health care financing system.

With the passage of Subchapter V of Chapter 115, Wis. Stats., and the Education of the Handicapped Act (EHA), local education agencies (LEAs) are required to provide special education to children identified as having exceptional educational needs (EEN). Many of these children require related services in order to benefit from special education. These special education and related services may include among others: audiology, nursing, occupational therapy, physical therapy, psychology, social work, and speech/language therapy.

School districts are finding it increasingly necessary to provide related services to assist and maintain students in their special education programs within their home communities. For example, a student may require occupational therapy services in order to develop the prerequisites to perform fine motor skills. In another situation a student may need nursing services for tracheostomy and gastric tube care.

Over the years, the number of students requiring these services has increased. We anticipate this growth will continue because:

1. More children who are medically fragile are surviving infancy.
2. More children with identified exceptional educational needs are deinstitutionalized.
3. More infants are born with neurological problems due to drug/alcohol abuse, AIDS, and so forth.
4. The severity of children's problems have increased, with a resultant increase in intervention time.
5. More EEN children with medical problems are integrated into regular education and require related services to enable them to function in the least restrictive environment.
6. Increasing numbers of young children (ages of 0-3) with related service needs will be attending early intervention programs.

As the need for services has increased, so has the cost. A February 1990 report entitled, "An Evaluation of Handicapped Education Programs," prepared by the Wisconsin Legislative Audit Bureau, found:

> Expenditures for occupational and physical therapy, which are included in the costs of instruction, increased more than 53 percent from 1984-85 to 1987-88. While some attribute this increase to an increasing demand for the services due to changes in enrollment and severity, it appears that the majority of these increases are due to the increasing costs of the services. The number of students provided physical or occupational therapy, or both, increased only six percent.
>
> District administrators said that it is becoming much more difficult to hire therapists as part of the district's regular instructional staff due to a shortage of personnel. As a result, an increasing number of districts have had to contract for these services through private hospitals and clinics. Costs for such services can be more than $50 an hour, as compared to less than $20 an hour for regular district staff.
>
> Although contracting for therapy services can be much more expensive, some administrators noted that, in smaller districts where demand for such services may require less than a full-time staff commitment, contracting can be economical. In such cases, a district only has to purchase services as needed. For example, the Bloomer school district requires only a few hours of physical therapy services a week. Contracting for services has allowed the district to pay for only the services it needs. However, as demand increases, the number of districts which will be able to take advantage of the purchase of services in individual units is expected to decrease. (p. 31)

We hope that this guide will assist local districts to access the health care financing system as a means to maintain and enhance special education and related services for students while offsetting local costs. Accessing the health care financing system is a new area with few precedents to guide LEAs. Consequently, LEAs must stay informed and be flexible in making changes as new information becomes available. We provide information in this resource guide on specific aspects of accessing third-party funds, including:

- Determination of an LEA's potential for third-party covered services.
- The need to become a certified provider dependent upon the funding source.
- Determining if LEA staff meet the qualifications necessary to become a certified provider.

- Establishing a system or mechanism to document relevant treatment-services data and translate that data into an appropriate third-party claim.

- Obtaining informed parental consent.

LEAs should recognize that this is a complex but manageable activity. The process of deciding whether to pursue accessing the health care financing system, implementing a billing procedure, and actually receiving funds will take time. Dividends may not be immediate, but by monitoring the program and allowing time for the system to work, this process may be another resource for your district.

Chapter 1

Historical Background:

Legal Basis for Third-Party Claims

Education of the Handicapped Act (P.L. 94-142)

When the Education of the Handicapped Act (EHA) and its implementing regulations were passed with language addressing the individualized education program (IEP) and designating special education and related services to be offered to handicapped students by local school districts, Congress failed to make clear whether this meant all fiscal responsibility as well as all implementation responsibility. Because this was not clear, many noneducational state agencies interpreted the "free and appropriate" phrase to mean that any services appearing on IEPs were indeed the fiscal responsibility of the school district. Education agencies, on the other hand, were told that they would receive federal dollars to help offset these costs.

The reality of the situation, however, is that Congress has never met its obligation to provide an appropriate funding level for the EHA. When the EHA required related services, defined as "transportation, and such developmental, corrective, and other supportive services (including speech-language pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education" (20 U.S.C. Sec. 1401), the health care industry withdrew fiscal support. Upon reviewing congressional records it did not appear that Congress intended for the total financial responsibility to shift to education agencies. Unfortunately, the wording in the actual legislation did not make clear how it was to be handled.

In summary, what P.L. 94-142 did was to give school districts the responsibility to see that students receive a free and appropriate education program, including necessary "related services" to help handicapped students benefit from their educational program. What P.L. 94-142 did not do was clearly state that the financial responsibility for special education and related services was to be shared by other state agencies/programs and private entities.

In order for school districts to successfully access Medicaid and third-party carriers, Congress had to make changes in the legislation's wording. P.L. 99-457 (Education of the Handicapped Act Amendments of 1986) is where Congress made some corrections.

EHA Amendments of 1986 (P.L. 99-457)

Congress considered the concerns expressed by state education agencies as well as recommendations from a General Accounting Office study on related services regarding the difficulty state and local education agencies were having bearing all the financial responsibility for the provision of special education. In passing P.L. 99-457, Congress took steps to ensure that state and local education agencies would not be required to bear all the financial burden for services covered by other entities prior to the enactment of P.L. 94-142. P.L. 99-457 describes education as the "payer of last resort." The areas covered in this legislation related to the definition of fiscal responsibility include:

- State plans reflecting interagency agreements defining each agency's financial responsibility.
- A nonsubstitution section indicating funds provided under 20 U.S.C. Sec. 1473 may not be used to satisfy a financial commitment for services which would have been paid for from another public or private source but for the enactment of this legislation.
- Policies adopted by state education agencies to ensure interagency cooperation.

The Medicare Catastrophic Coverage Act (P.L. 100-360)

On July 1, 1988, the Medicare Catastrophic Coverage Act was signed into law. The main thrust of this legislation was Medicare, but it contained a significant amendment to the Social Security Act relating to the financing of related services included in a student's individualized education program (IEP) under Part B or individualized family service plan (IFSP) under Part H of the EHA. This amendment stated that Medicaid could not use the fact of services being required by a child's IEP or IFSP to restrict or prohibit reimbursement for those services.

The section in P.L. 100-360 relating to education stated:

> TREATMENT OF EDUCATIONALLY-RELATED SERVICES
>
> (A) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (b) the following new subsection:
>
> "(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individualized education program established pursuant to Part B of the Education of the

Handicapped Act or furnished to a handicapped infant or toddler because such services are included in the child's individualized family service plan adopted pursuant to Part H of such Act."

Even though Congress repealed P.L. 100-360 in 1989, the amendment that addressed subsection (c) remained. This amendment clearly states that claims to Medicaid cannot be denied based solely on the fact that the service is included in a student's IEP or IFSP.

Each piece of legislation gives education agencies a part of the puzzle. The details are left to be worked out among the concerned parties within each state. Congressional intent was to lay the framework of coverage for health related services and allow each state to build a plan appropriate to its needs.

The legislation reviewed in this chapter can be summarized as follows:

P.L. 94-142 mandated specific services to be covered for handicapped students. Unfortunately, the language in this law was not specific in establishing who had financial responsibility for the related services schools would be providing under the legislation.

P.L. 99-457 introduced clearer language on interagency agreements and gave states a clear directive to use all possible funding sources for these programs before utilizing federal dollars. Congress stated that other sources may include private insurance as well as other state health agencies.

P.L. 100-360 amended the Social Security Act by specifying that Medicaid can not prohibit or restrict payment for covered services provided to a handicapped student because such services are included in a student's IEP or IFSP.

Among court cases that relate to third-party payments involving private insurance companies are the following:

Seals vs. Loftis, 614 F. Supp. 302, 305 (E.D. Tenn 1985).

After determining that a service rendered by a school district was within the meaning of the EHA, the court held "... that parents of a handicapped child cannot be required to utilize their private medical insurance benefits where the utilization of those benefits would cause them to incur a financial cost." The district was ordered to reimburse the parents for the amount of insurance proceeds paid for the services because that payment would have reduced the lifetime benefits available to the parents under their policy.

Gehman vs. Pennsylvania Commonwealth Dept. of Education, 702 F. Supp 1192, 1194 (E.D. Pa. 1989).

In this case brought before the court, a child had suffered severe head injuries in an automobile accident resulting in a need for special education. The insurer initially paid for specific services, but subsequently refused to do so arguing that the school district and state were responsible for the services. The court held that, "private insurer's obligation to the child injured in the accident which resulted in need for special education had no absolute connection with the obligation of the school district to provide appropriate education; thus, the child may be entitled to medical or other benefits from the insurer in addition to education from the school district."

Chester County Intermediate Unit v. Pennsylvania Blue Shield, 896 F. 2d 808; (3rd Cir. 1990).

The Third Circuit Court of Appeals held that the EHA does not obligate private insurers to pay for special education services when an insurance policy specifically excludes coverage of services which are provided at public expense. Thus, insurance companies may contractually exclude from coverage those services which are free under the EHA.

Chapter 2

Cautions in Accessing Third-Party Funds

and

Gaining Parental Support

The Department of Public Instruction (DPI) recognizes that accessing third-party funds to help offset the costs of providing special education and related services to students with exceptional educational needs (EEN) is an avenue that local education agencies (LEAs) may want to explore. If LEAs pursue third-party funds, they must proceed with a full understanding of the positive and negative aspects of accessing Medicaid and private insurance plans. This is an activity that has been explored in other states and districts, and Wisconsin can benefit from their findings.

LEAs must keep certain cautions in mind as they access third-party funds. In 1980 the U.S. Department of Education, through the secretary of education, published a Notice of Interpretation stating:

> The Secretary interprets the requirements that a free appropriate public education be provided "without charge" or "without cost" to mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of handicapped children would suffer a financial loss not incurred by similarly situated parents of non-handicapped children. Financial losses include, but are not limited to, the following:
>
> (1) A decrease in available lifetime coverage or any other benefit under an insurance policy;
>
> (2) An increase in premiums or the discontinuation of the policy; or
>
> (3) An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim. (45 FR 86390, Dec. 30, 1980)

This notice informs LEAs desiring to bill parents' insurance plans that if they cannot guarantee the above three items, they may not require parents to use their insurance. (Appendix B contains a copy of the complete Notice of Interpretation.)

The best way to address these issues is to secure the permission of parents to access their insurance plans while giving them the right to refuse. It is virtually impossible to ensure no loss in lifetime benefits, unless a policy has no maximum. Since a no lifetime maximum is unusual, anytime a claim is filed, lifetime benefits are reduced somewhat. However, parents may be more

willing to grant LEAs permission to access their insurance plans after this aspect is explained to them.

Parent permission addresses another caution; that is, parents must grant informed, written consent before an LEA can file a claim with the parents' insurance plans. Informed consent means that parents have been provided with a full and complete explanation of their due process rights along with the following:

- That there may be a reduction in the lifetime benefit cap when the LEA bills for certain services. This may not create a problem for parents, but they must be informed.

- That consent to bill third-party payers is purely voluntary. In addition, parents must be assured that their consent or refusal will in no way alter the quality, type, or duration of services for their child as specified in the child's IEP.

- That if the parents' insurance plans require a co-payment or deductible on a school based claim, the LEA will cover these costs. LEAs must absorb these costs for students based on "free and appropriate public education" in the EHA. This sometimes is an incentive for parents to grant consent, since they then might not have to satisfy a deductible for services rendered outside the school.

Some additional aspects and cautions LEAs should be cognizant of when accessing third-party funds are:

- LEAs should be able to provide parents with an estimate of the amount expected to be billed to their insurance. In addition, the amount actually claimed to and the benefits received from the insurance company should be disclosed to parents at least annually.

- Information about students receiving special education and related services must be kept confidential. Thus, LEAs must adhere to the regulations of the Family Educational Rights and Privacy Act (FERPA) when disclosing information to insurers from which one is seeking third-party benefits. In addition, the confidentiality, maintenance, and release of other information from records considered medical relative to accessing the health care financing system should be compatible with those standards imposed on patient health care records under s. 146.81-83, Wis. Stats.

- LEAs should be familiar with the proper methods for determining fees.

- LEAs electing to seek third-party payment for services must meet conditions of participation, for example, provider certifications before billing a third-party payer. In addition, the LEA must meet the documentation and reporting requirements of the third-party payer.

- o LEAs should be aware that third-party payers may limit payment of a "covered" service to a specified dollar amount or number of "treatment" sessions.

- o Some medical or health insurance plans may contain provisions which exclude coverage of services which are provided at public expense.

An important aspect LEAs must remember is that the IEP is developed as it always has been, addressing the student's educational needs and identifying any related services which may be required in order for that student to benefit from an exceptional educational program. This process must be completed regardless of the funding source; third-party payments as a funding source have no bearing on what is or is not included in the IEP. LEAs must always remember that they are obligated to provide whatever is specified in the IEP, regardless of funding source. LEAs cannot remove an item from the IEP or elect not to provide for something that is specified in the IEP because private insurance or Medicaid will not allow benefits for that service.

Gaining Parental Support

One of the first and most important activities an LEA can undertake as it considers accessing third-party funds is to keep parents informed. It is critical for parents to know from the start what the LEA is considering and why it is being considered.

Parent education is at the top of the list of things to do. LEAs need parents on their side when they start this process. If parents are unhappy with the decision or feel uninformed about the process, they might encourage other parents to refuse to allow LEAs to bill their insurance. The cautions previously listed give LEAs a good idea of what to tell parents. If these areas are explained openly and honestly to parents, LEAs should encounter few difficulties gaining parental support.

Chapter 3

The Delivery of Health Care Services in an Educational Setting

Since the passage of Subchapter V of Chapter 115, Wis. Stats., and the EHA, school districts have been providing related services to EEN students who require these services to benefit from their special education programs. Many of these related services can be regarded as medical in nature and viewed as health care services. However, emphasis has been on school districts providing these related services for educational reasons rather than for medical reasons; that is, providing these services enables students to participate and progress in their instructional programs. Related-service staff roles have expanded from giving direct intervention to the child to including consulting with the classroom teacher, inservicing families and staff, assessing the need for and ordering adaptive equipment, and acting as liaison with health care providers in the community.

From a financial perspective, the educational and medical models are not mutually exclusive. The direct related service provided an EEN student can also be viewed fiscally as a medically necessary service given by a medical provider to a patient.

Educationally the process remains the same. A student is referred because of a suspected EEN. The multidisciplinary team (M-team) evaluates the child and determines whether the student has an EEN. The M-team also may recommend related services which the child may require to benefit from the special education program. The IEP committee, in developing the goals and objectives for the child, then determines whether related services are necessary and, if so, notes the frequency, level, and duration of the related service(s).

The related service(s) in the IEP can now be viewed fiscally. If third-party payers consider an educationally related service to be medically necessary and it is rendered by a qualified provider, then the cost associated with this service may be eligible for payment by a third-party payer.

Thus, the M-team and IEP process remains the same. The school district is obligated to provide the amount of related service as specified in the student's IEP. For financial purposes, the related service can then be evaluated in terms of accessing third-party payment.

The following factors should be considered when examining related services for possible third-party payment:

1. Is the service medically necessary?

   Payment for a service may be dependent upon the referral or prescription of the service by a physician.

2. Does the provider meet medical qualification standards?

   Though school staff are certified and licensed by the Department of Public Instruction (DPI), they may not meet the qualification standards of the applicable medical boards/associations to be considered a medical provider. The Wisconsin Medical Assistance Program (WMAP) and most medical insurance plans require medical providers to meet certain qualifications before granting payments for their services. WMAP has set certain standards for providers which are enumerated in Health and Social Services (HSS) chapters of the Wisconsin Administrative Code, while other third-party payers may require that providers meet standards outlined in the Code of Federal Regulations (42 CFR Ch. IV). School district personnel are encouraged to keep abreast of WMAP and private insurance requirements relative to provider qualifications. (See Appendix C for a description of the qualifications of certain providers as required by WMAP and private insurance plans.)

3. Can some or all of the amount of service, as specified in the IEP, be billed?

   Usually direct service intervention (student contact) is billable. Time spent in consultation, attending meetings, writing reports, or ordering equipment may not be billable.

It is important to emphasize that services provided must remain focused on the needs of the student, thereby enabling the student to benefit from the educational program. Services provided should not be based on anticipated receipts or lack thereof from third-party payers.

A natural concern exists regarding an increase in paperwork for staff. Information already collected by the district will meet some of the requirements of third-party payers (data required by third-party payers is discussed in Chapter 7). Some additional information, in terms of units of service, may need to be collected. WMAP's prior authorization process for such services as occupational therapy, physical therapy, and speech therapy is discussed in Chapter 4.

Chapter 4

Wisconsin Medical Assistance Program Coverage of Medically Necessary Services Provided In The Schools

The Bureau of Health Care Financing, Wisconsin Department of Health and Social Services, stated in it's August 10, 1990, Medical Assistance Provider Bulletin (MAPB-090-021-D) that:

> Federal law, P.L. 100 - 360, 'The Medicare Catastrophic Coverage Act' Section 411 (k)(13), (effective July 1, 1988) clarifies that Medical Assistance (MA) agencies are financially responsible for any covered, medically necessary services which are included in the Individualized Education Plan (IEP) of a handicapped child who is a MA recipient. Services such as speech pathology, occupational therapy, and physical therapy, are examples of covered therapy services that may be identified as needed in a child's IEP. (page 2)

Whether or not services in a student's IEP are covered by WMAP will be determined by the Bureau of Health Care Financing in accordance with WMAP related statutes, rules, and policy guidelines. There are four prerequisites to coverage:

1. The student must be eligible for WMAP on the date of service.
2. The services must be rendered by a provider certified with WMAP for the date of service.
3. The services must be medically necessary (in other words, all therapy and other professional services not performed by a physician must be prescribed by a physician).
4. The services must be provided in accordance with WMAP guidelines.

Limitations may be placed on coverage in regards to the frequency of the service, type of service (treatment) covered, where the service is provided, and diagnoses that are covered.

WMAP covers medically necessary services provided to eligible recipients. It generally will not cover activities such as consultations, parent conferences, travel time, and so forth. Districts will need to refer to the Wisconsin Administrative Code Rules for WMAP which are enumerated in Health and Social Services Chapters HSS 101-108 as well as specific provider handbooks and bulletins for more detailed information on covered services and limitations.

Provider bulletin MAPB-090-021-D also contains information related to coverage of some of the medically necessary services provided in the schools. The following information is important for school districts to be aware of when seeking funds from WMAP.

Certification for Services Provided in the Schools

No additional certification is necessary if a provider is already certified to provide WMAP services. Qualified therapists employed by or under contract to schools may become certified by WMAP and bill for covered services for eligible children. Please refer to provider-specific handbooks and bulletins for certification requirements. School districts may obtain a therapy group billing number which, when billed in conjunction with a performing provider number, can be used to centralize the billing for therapists in the district. Claims submitted for services provided by noncertified providers are denied. (MAPB-090-021-D, page 2)

When school personnel become certified with WMAP, they will receive provider-specific handbooks and bulletins which contain complete information on covered services, related limitations, procedures, and billing instructions. LEAs which are going to pursue WMAP payments for services should obtain certification in each applicable area in order to obtain all necessary information. Since policies are unique to each service area and are subject to frequent changes, only general concepts will be communicated in this guide.

Place of Service Code

The appropriate place of service (POS) code for all therapy services provided in the school is "0" (Zero). The service may be provided in the school by a therapist directly employed by the school or by a therapist under separate contract with the school. (MAPB-090-021-D, page 2)

Prior Authorization

Several service areas require prior approval from WMAP before services can be provided. Specifically, documentation supporting the medical necessity of the service for the recipient must be submitted. If the service is identified in the student's IEP, the IEP should be included with the prior authorization request so that the prior authorization will cover the same time period. Examples of services requiring prior authorization as of January 1, 1991, include: all therapy services after 35 treatment days

by any provider(s) for one spell of illness*, mental health services after $500 or fifteen hours of service in a calendar year, and hearing aids and other durable medical equipment. (Refer to Appendix H for an illustration of WMAP therapy prior authorization request and spell of illness forms.)

Billing for Services Provided in the Schools

Certain MA recipients are enrolled in health maintenance organizations (HMOs) which are expected to provide all the services for the child. However, services provided in the schools are exempt from this requirement. All claims for reimbursable services provided in the schools must be submitted to E.D.S Federal Corporation (the fiscal agent for WMAP) for payment even if the child is enrolled in a WMAP-contracted HMO. Services provided to a recipient enrolled in a WMAP-contracted HMO, which are billed POS "0", are reimbursed on a fee-for-service basis by WMAP. Providers in Milwaukee, Dane, and Eau Claire counties should pay particular attention to this. Please refer to Section IX-E of Part A of the WMAP Provider Handbook, for more information. (MAPB-090-021-D, page 2)

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*Spell of illness means "... a condition characterized by a demonstrated loss of functional ability to perform daily living skills, caused by a new disease, injury or medical condition, or by an increase in the severity of a pre-existing medical condition. For a condition to be classified as a new spell of illness, the recipient must display the potential to reachieve the skill level that he or she had previously." (HSS 101.03, Wis. Adm. Code)

Chapter 5

The Health Care Financing System

Medical insurance is a system of protection against loss of property. Individuals, groups of individuals, or employers for their employees and dependents agree to pay periodic sums of money (premiums) for a guarantee they will be compensated (indemnified) under stipulated conditions and at specific rates for monies expended or debts incurred for the receipt of medical care services. Although this manual will use the terms "medical insurance" and "health insurance" interchangeably, the majority of insurance contracts in force in Wisconsin reimburse for the treatment of an illness or injury, not for the costs incurred to achieve or maintain a certain health status.

The public school system must ensure that all identified EEN students have access to a free and appropriate education. Those students who receive special education and related services (for example, physical, occupational and speech therapy, and audiology) must have access to such services at no extra cost to their families. Thus, families must be assured they are at no extra risk for loss of property (for example, diminution of available insurance benefits) as a result of an LEA contact with private insurance plans.

Private medical/health insurance is a subsystem within the total system of health care financing. Indeed, the concept of health care financing conjures a broader picture that includes both the private and public sectors.

It is appropriate for an LEA to project itself as an entity accessing this health care financing system. By definition, there is no risk to avoid or loss to compensate; hence, the resultant health care financing system dollars would take on the context of operating funds in the same vein as the state's categorical handicapped aids program administered by DPI. The thrust of this manual then is to comply or adhere to the context of the health care financing system.

The health care financing system consists of individuals, groups of individuals, or organizations categorized as: (1) the patient or first-party, (2) the service provider or second-party and (3) an insurance entity or third-party. A contractual relationship is established between the patient and provider when the patient asks the provider to perform services in exchange for the patient's consent to promptly pay the provider a customary fee for the services performed. The third-party has no binding interest in the patient-provider contract. The third-party's contractual relationship is with the insured patient. An exception to the patient-provider rule concerns the provider's relationship when treating WMAP recipients. Court decisions have declared that the

WMAP recipient is a third-party beneficiary to the provider-state contract.

However classified, the LEA will attempt to extract from the health care financing system monies to help fund the costs of services provided to the student receiving special education. To properly manage this financial activity, the LEA should develop an accounts receivable system analogous to the patient accounts subsystem within a health care provider's overall management information system. The use of patient accounts by educators is not seen as a summary of patient/student liability but rather as a control mechanism. A properly managed patient accounts system can help ensure maximum health care financing system funds payments in a timely, cost-efficient manner.

The concept of a student/patient accounts system will be addressed later in this manual. To help place such a system in proper perspective, it is necessary to have a basic understanding of financial related medical terminology (see the Glossary) and of the primary players in the health care financing sector.

Third-party payers are either public or private entities. Those public entities of concern to the LEA include: Wisconsin Medical Assistance Program, Civilian Health and Medical Program of the Uniformed Services/Civilian Health and Medical Program of the Veterans Administration (CHAMPUS/CHAMPVA), Wisconsin Health Insurance Risk Sharing Plan (HIRSP), and Wisconsin's Program for Children With Special Health Care Needs which is administered, at publication date of this manual, by DPI's Bureau for Children With Physical Needs (BCPN).

The private sector provides individual or group insurance coverage administered, in various forms, by commercial carriers, self-insured groups, and managed-care companies (HMOs, Preferred Provider Organizations, and so forth). What follows are definitions or illustrations of these third-party options.

Wisconsin Medical Assistance Program

The Wisconsin Medical Assistance Program provides insurance coverage for medical and rehabilitative services. The federal government reimburses Wisconsin for a portion of the benefits made available by WMAP. Within federal guidelines, the individual states can offer a varying array of services under their medical assistance plans. Wisconsin's medical assistance plan is generally regarded as one of the more progressive in terms of benefits made available to its clients. The current federal share is approximately 59% of allowable benefits.

WMAP, often referred to as Title XIX or Medicaid, is administered by the Bureau of Health Care Financing (BHCF) within the Department of Health and Social Services (DHSS). The BHCF administers the program within federal and state guidelines pertaining to

eligibility criteria, type and scope of coverage, claim reimbursement levels, and administrative procedures.

Eligibility

There are both nonfinancial and financial conditions for eligibility under WMAP. To be nonfinancially eligible, a person shall be Aid to Families With Dependent Children (AFDC)-related or Supplemental Security Income (SSI)-related.

An AFDC-related person, who might also be of school age, is defined as: (1) pregnant and meets other statutory requirements, and/or (2) a dependent child, and/or (3) a foster child under 19 years of age living in a foster home or a child in a subsidized adoption placement. More complete definitions are found in Chapters 48 and 49 of Wisconsin Statutes.

An SSI-related person, who might also be of school-age, must be blind or disabled. A child is considered blind when having vision no better than 20/200 or a limited visual field of 20 degrees or less in the better eye with the use of eyeglasses. A child under 18 may be found disabled with a physical or mental impairment that is comparable in severity to one that would prevent an adult from working and is expected to last at least 12 months or result in death. Findings of disability are determined by staff of the Disability Determination Bureau within DHSS's Division of Vocational Rehabilitation.

Other nonfinancial conditions or considerations for WMAP eligibility, applicable to a school-age child, pertain to: (1) citizenship or legal resident-alien status, (2) Wisconsin residency, (3) social security number identification, and (4) detainment via the legal system.

Once nonfinancial conditions are met, the WMAP applicant is tested next against financial asset and then income standards. Financial resources are defined to include any cash, liquid asset, or real or personal property a person owns that could be converted to cash to be used for support or maintenance. Some resources are excluded in determining asset limit eligibility: (1) the home in which the applicant lives, (2) limited amounts in household goods and motor vehicles, (3) property essential for self-support, (4) cash value of life insurance, and (5) burial spaces and funds.

An applicant not meeting the asset test cannot become WMAP certified, no matter the extent of medical bills (except for Healthy Start applicants).

If the asset test is met, then the applicant's income is compared to established standards. Income can include that which a person receives in cash or in-kind (noncash) proceeds. Exact definitions of what constitutes assets and income can be found in

Chapter 103 of the Wisconsin Administrative Code and further explained in Part A of the WMAP Provider Handbook.

Appendix D reflects the asset and income levels, effective July 1990, for categorically needy and medically needy WMAP eligibility. Persons who receive AFDC or SSI benefits are entitled to categorical (that is, automatic) WMAP eligibility status. Those persons not receiving AFDC or SSI benefits can also be found MA eligible if they:

- o meet specific nonfinancial requirements;
- o have a family income below the MA medically needy income limit for their family size; and
- o have family assets below the MA medically needy asset limit.

The asset limits are set by the Wisconsin Legislature. The income limits are calculated based upon a formula described in federal law and regulation. This formula uses the SSI payment (for SSI-related applicant/recipients) and the AFDC payment (for AFDC-related applicant/recipients) as its basis. The formulas used for one and two member applicant/recipient groups are fairly complicated.

The formula used to determine the medically needy income limits for AFDC-related households is 133% of the AFDC payment for that size group. The AFDC payment is also set by the Wisconsin legislature. In 1990, the AFDC payment was approximately 70% of the federal poverty line published by the Office of Management and Budget.

An applicant can achieve medically needy status if the asset test is met and if historical or current medical expenses are still the applicant's or family's liability. This "deductible" procedure will test to see if there are sufficient medical expenses already incurred but not paid or payable by a third-party which, when subtracted from available income, would lower the countable income below the medically needy standard.

Once eligibility has been determined, a medical assistance card is generated for the recipient. Each recipient has a WMAP identification number of ten digits; the first nine digits are usually the recipient's social security number, while the tenth (default/tiebreaker) digit is usually 0.

Effective for dates of services after June 30, 1990, categorical and medically needy recipients are eligible to receive the same level of WMAP benefits.

Appendix D lists the number of WMAP eligible recipients under age 21 by county/reservation as reported by DHSS on August 31, 1990.

HMO-PEI

Under the WMAP Health Maintenance Organization-Preferred Enrollment Initiative (HMO-PEI), enrollment in a participating HMO is mandatory for certain Medical Assistance-eligible recipients in selected counties. Recipients enrolled in one of these WMAP-contracted HMOs are informed that they must receive all Medical Assistance-covered services, with the exception of any HMO noncovered services, from providers affiliated with that HMO. HMO-PEI enrollees may receive on a fee-for-service basis from any WMAP certified provider certain services covered by WMAP but not included in the HMO contract.

As of July 1990, HMO-PEI counties are Milwaukee, Dane, and Eau Claire. Recipients certified via the Katie Beckett Program and SSI are exempt from the HMO-PEI initiative.

Related to therapy, a July 1990 directive from WMAP states that all Medical Assistance claims for physical, occupational, and speech therapy services provided by certified providers in the schools should be billed to E.D.S Federal Corporation on a fee-for-service basis regardless of whether the student is assigned to a Medicaid HMO.

Other WMAP Initiatives

What has been presented so far is a general outline of the conventional WMAP eligibility determination process. Many nuances exist to the basic model; however, the description of most of these circumstances is beyond the scope and intent of this manual. What does deserve mention are those initiatives which can permit WMAP certification outside the conventional process and serve to increase the number of potential WMAP eligible clients who are also of school age.

Healthy Start

The Healthy Start program targets pregnant women as well as children under age six who fail both the categorically and medically needy tests required by the regular application process. Under Healthy Start, there is an income test but no asset limitation. As of July 1990, the income limits under Healthy Start are 133% of the federal poverty level for categorical status and 155% for medically needy status. Appendix D reflects the Healthy Start income standards for different size applicant groups. The "deductible" option is also available to meet Healthy Start medically needy status.

DHSS estimates that the Healthy Start initiative will provide the potential to increase WMAP rolls by 40,000 persons, including 35,000 dependent children.

Katie Beckett

Katie Beckett provides WMAP certification for certain disabled children living at home who might otherwise be ineligible for WMAP coverage because family income/assets exceed conventional WMAP limits.

To be eligible, the child must be 18 years of age or younger and be classified as disabled under standards established by the Social Security Administration. The child must require a level of care commensurate with that typically provided in an inpatient hospital setting or nursing facility. The child need not have a history of institutionalization; rather the level of care requirements are determined based on the child's current medical condition. The child must be able to receive an appropriate level of care outside an institutional setting.

The total annual cost to WMAP cannot be greater than the amount which would be expended over a year's time in an institution.

The income and assets of the child's parents are not considered when determining a child's financial eligibility status under Katie Beckett. However, financial eligibility standards do set limits for child-owned assets ($2,000) and child monthly income ($1,158).

As of July 1990, there are approximately 2,000 children deemed medically eligible under Katie Beckett. Probably 90% of these children would not have WMAP certification were it not for the unique Katie Beckett eligibility criteria.

A Katie Beckett-eligible child is entitled to the same level of coverage provided any other WMAP recipient.

WMAP Recipient Responsibilities

Along with WMAP certification, a recipient takes on certain responsibilities of interest to an LEA. Recipients must inform providers that they are receiving benefits under WMAP. They are required to disclose to providers who ask complete and accurate information necessary for the correct submission of claims. If a recipient has other medical insurance in addition to WMAP, such details must be given to the service providers, if requested.

WMAP Provider Eligibility, Certification, and Responsibilities

The Wisconsin Medical Assistance Program is defined in Chapter 49 of the Wisconsin Statutes. Chapters HSS 101-108 of the Wisconsin Administrative Code are promulgated for the purpose of administering the Medical Assistance program. WMAP provider handbooks and bulletins give WMAP providers complete and current information on Medical Assistance policies and billing procedures.

Part A of the WMAP Provider Handbook contains general policy guidelines, regulations, and the like applicable to all types of WMAP certified providers. There are service specific handbooks (for example, Part P-Therapy: Occupational, Physical & Rehabilitative) which include information applicable to a specific provider type.

If there is any conflict in the meaning between Chapters HSS 101-108 of the Administrative Code and the handbooks, the meaning of the Wisconsin Administrative Code will hold. Wisconsin Administrative Code books and a subscription to an update service can be purchased through the Department of Administration's Document Sales and Distribution.

In addition to handbooks, providers are periodically issued bulletins regarding ongoing policy changes. Providers should maintain these bulletins with the provider-specific handbooks to ensure maintenance of and access to the most current information.

School districts and/or their employees who wish to become WMAP certified providers should contact the E.D.S Federal Corporation Correspondence Unit. Correspondence telephone numbers are 1-800-323-0847 (in-state toll free) or 608-221-9773 (local and out-of-state) for the following counties: Dodge, Fond du Lac, Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Rock, Sheboygan, Walworth, Washington, and Waukesha. For all other counties use 1-800-323-0861 (in-state toll free) or 608-221-9236 (local and out-of-state). Written requests for certification may be sent to E.D.S Federal Corporation, Attention: Provider Certification, 6406 Bridge Road, Madison, WI 53784-0006.

Newly certified providers are sent a copy of Part A, the appropriate service specific handbook, and all relevant bulletins issued since publication of the service-specific handbook.

WMAP provider rights/responsibilities and certification processes are enumerated in Chapter HSS 105-106 of the Wisconsin Administrative Code and are further explained in Part A, Sections II through IV of the WMAP Provider Handbook.

An entity that becomes WMAP certified takes on certain federal and state requirements relating to nondiscrimination, required records, availability of records to WMAP authorized personnel, confidentiality, and acceptance of payment.

All service providers who receive payment from WMAP, and as a practical matter from any third-party insurer, must maintain records which fully document the basis of charges upon which claims are filed. The specified records for school-based services must be retained for a period not less than five years from the date payment is received for a particular service. Such records include medical and financial related documentation. Financial records include quantity and dollar value of services; thus, copies of actual HCFA 1500 claim forms filed to WMAP and

private insurers along with documentation of services provided, providers, and related costs should be kept for the five-year time frame.

All providers, whether individuals, agencies, or institutions, must have an eight-digit provider number to bill WMAP for services rendered to a WMAP recipient. There are three types of provider numbers: (1) billing-performer provider (2) nonbilling-performer provider and (3) group billing.

A billing-performer provider number is used by those individuals and institutions who may independently bill WMAP.

A nonbilling-performer provider number is used by those individuals who must be under professional supervision to be eligible WMAP providers. A nonbilling-performer provider, including physical and occupational therapy assistants, must submit claims to WMAP using one of two methods: the nonbilling number as the performer provider, in conjunction with (1) the billing-performer provider number of the individual supervising the service or (2) the group billing number of the employer if it is a WMAP-certified facility/agency.

A group billing number by itself will not generate payment. It is used primarily as an accounting convenience and can be issued to school districts that want all payments made directly to the district for all covered services of a specific type (for example, therapy) rendered by district staff or contractors. A group billing number must always be used in conjunction with a performing provider number, except in specific cases including but not limited to HealthCheck and Durable Medical Equipment (DME) purchases.

WMAP also issues a "billing service" number to those entities that perform only electronic claims activities for WMAP-certified providers. WMAP does not issue an identifying number; hence, it does not track the relationship between, for example, an LEA and a "third-party administrator" who contracts with the LEA to perform third-party activities described in this manual.

WMAP HealthCheck Program

HealthCheck is Wisconsin's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The federal government mandates all states to include EPSDT as a part of their medical assistance program.

The EPSDT concept envisions comprehensive and preventive health services for children by means of: (1) outreach, (2) health education, (3) screening, (4) diagnosis, (5) treatment, and (6) case management. Outreach activities are those that seek out eligible at-risk children and their families to inform them of the benefits of preventive actions and the health services available to them. Health education objectives are designed to help

children and their families by demonstrating how to use health care resources (including their own talents and abilities) effectively and efficiently. Screening services assess a child's health status via initial then periodic examination and evaluation. Case management activities are meant to ensure that health problems are found, properly diagnosed, and treated to prevent degeneration which would cause more complex and costly future problems. Treatment includes immunizations, if needed, and necessary medical, dental, vision, and hearing care services whenever the need is indicated during the screening activity.

Federal Medicaid regulations allow individual states to offer certain services to the EPSDT client without having to make these same services available to the general Medicaid population. For example, Wisconsin provides coverage for orthodontic services to children who satisfy special medical criteria but only to those who have completed the EPSDT process.

Wisconsin promotes its HealthCheck program as a comprehensive, preventive health examination and evaluation process for children and young adults under age 21 who are eligible under the Wisconsin Medical Assistance Program. Screening services, consistent with recommendations of the American Academy of Pediatrics, are limited, based on age, to the following frequency for a consecutive 12-month period:

- 6 screens, birth to one year
- 3 screens, age one to two
- 2 screens, age two to three
- 1 screen, age three to twenty-one

Components of the HealthCheck screen include:

- health and development history
- unclothed physical examination
- nutritional assessment
- blood pressure for children over 3 years old
- head circumference for children up to age one
- vision examination
- hearing examination
- oral assessment and mandatory dental referral, when appropriate, for all children 3 years and older
- immunization, when needed

Wisconsin demonstrates its commitment to the comprehensive, preventive HealthCheck concept by providing payment at a higher level for EPSDT services then would be paid for traditional comprehensive or preventive exams for WMAP clients under age 21.

WMAP-certified physicians are eligible to become certified as HealthCheck providers. In addition, public health agencies, local school districts, and certain other providers, under physician supervision, can apply for WMAP certification as HealthCheck providers.

The Omnibus Budget Reconciliation Act of 1989 (OBRA89) modified Medicaid's mandatory EPSDT program. Some advocates for children with special health care needs and other interested parties have characterized OBRA89 as a significant enhancement of EPSDT services available to the Medicaid-eligible at-risk population.

Historically, the EPSDT process was not consistently used as a diagnostic/treatment tool. Wisconsin has demonstrated an average 20% utilization rate, compared to the national average of 25%. However, OBRA89 mandates states to demonstrate an 80% screening rate for all Medicaid clients under age 21 by 1995. To help meet the 1995 screening mandate, WMAP is encouraging school districts that meet the staffing requirements outlined in HSS 105.37 to seek HealthCheck-provider certification. As of October 1990, HSS 105.37 does not specifically list school districts among those providers eligible for HealthCheck certification; however, the code does refer to "clinics operated under a physician's supervision." The administrative code also stipulates that

> EPSDT health assessment and evaluation services shall be delivered under the supervision of skilled medical personnel. In this section 'skilled medical personnel' means physicians, physician assistants, nurse practitioners, public health nurses or registered nurses. Skilled medical personnel who perform physical assessment screening procedures shall have successfully completed either a formal pediatric assessment or an inservice training course on physical assessments approved by the department. Individual procedures may be completed by paraprofessional staff who are supervised by skilled medical personnel. Registered nurses who perform EPSDT physical assessments shall have satisfactorily completed a curriculum for pediatric physical assessments approved by the department. (HSS 105.37(1)(b)2.)

WMAP is encouraging school districts who meet the staffing requirements established in the administrative code to seek HealthCheck provider certification. School districts could apply for their WMAP HealthCheck provider status using the argument that they should be considered comparable to "clinics operated under a physician's supervision."

Some LEAs have already attained HealthCheck-provider status and have implemented an EPSDT program. Some of the considerations LEAs should account for as they consider this service option for students include:

- Personnel - licensed health professional nurse or physician (a school health program must operate under a physician's supervision) and individuals trained in physical assessment skills

- Equipment - vision-acuity testing charts appropriate for age; audiometer--pure tone testing*; tape measure; blood pressure equipment with age-appropriate cuffs; stethoscope; percussion hammer; scale; thermometer, oral and rectal; unit to test either hemoglobin or hematocrit with supplies*; and otoscope/ophthalmoscope*

- Supplies - examination gowns--adolescents; gloves; diapers; labstix (dip stick urinalysis); and educational pamphlets and materials--age-appropriate for children and youth

- Facilities - locked medical file--records; interview area; private exam area--screened; running water--sink; and toilet

- Time - 45 minutes - 1 hour/exam; complete during regular school day (time out of classroom); or complete outside school time (transportation to and/or from exam site--could be reimbursable)

- The parent need not be present, telephone contact or a home visit can obtain health history; verification of medical assistance eligibility required

- Same service can be offered to non-Medicaid students on a fee-for-service or co-payment basis

- Immunizations can be referred to the local health department, and laboratory tests can be referred to local agencies or physician providers

- Consider adding a case management/outreach component

Why would a local school district want to provide HealthCheck services for some of its students? HealthCheck screening services in schools provide a unique opportunity to perform a comprehensive, preventive health assessment of children who may not have been reached in the past. Changes in family dynamics, such as an increased number of single-parent households, both parents working outside the home, or parental confusion with the health care system, have contributed to a perception of and actual inaccessibility to needed medical services. Approximately 80% of Wisconsin children eligible for HealthCheck services do not receive those services. A clear relationship exists between good health and the ability to learn. Early detection and treatment of a student's health problems can have a significant impact on school performance.

If you wish additional information about the HealthCheck program, contact the Bureau of Health Care Financing at 608-266-9438 or 608-267-0938.

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*High cost items -- consider rentals

Health Insurance Risk Sharing Plan

Wisconsin's Health Insurance Risk Sharing Plan (HIRSP) was created with enactment of Chapter 313, Laws of 1979. The Plan can provide medical insurance for those persons unable to obtain adequate and/or affordable insurance coverage via the private market. The Plan's target population are those persons the private sector often excludes from coverage because of mental or physical impairments.

HIRSP is available to all school age children who, because of a mental or physical impairment, have received within nine months of application, one of the following:

- a notice of rejection or cancellation from at least one private insurance carrier,
- a notice of reduction or limitation of coverage via an existing policy which reduces one's coverage substantially below that available to persons considered by the private sector to be of standard risk.
- a notice of premium increase, exceeding the premium rate then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's policies then in effect.

HIRSP does not provide dependent coverage to the family of an applicant. In effect, all applicants are issued their own policy. Technically, school age children covered by HIRSP are the policyholders, because the HIRSP coverage is issued under the child's name. The State of Wisconsin has funds budgeted to help low-income policyholders pay their HIRSP premiums and reduce deductible amounts. (Appendix D contains the HIRSP premium rate schedule effective for 1990.)

As long as premiums are paid, HIRSP policies will remain in force until: (1) the first day of any policy term for which a premium is paid or reimbursed by a federal, state, or local governmental entity or (2) the day after the last day of any policy term in which a deductible or coinsurance amount is paid or reimbursed by a federal, state, or local governmental entity. Item (2) does not apply if such payments are made by government programs for (a) vocational rehabilitation, (b) renal disease, (c) hemophilia, (d) cystic fibrosis, (e) children with special health care needs, or (f) special education under s. 115.77, Wis. Stats. Items (1) and (2) do not apply to persons receiving assistance under Section 619.165 of the Wisconsin Statutes, which refers to the subsidized-premium and reduced-deductible option for low-income HIRSP enrollees.

The HIRSP does cover such services as physical, occupational, and speech therapy; outpatient treatment of nervous and mental disorders; and audiology if such services are deemed medically neces-

sary. Regular HIRSP policies call for an initial $1,000 deductible, followed by 80% coverage of the next $5,000 in "usual and customary" charges, and then by 100% coverage-all on a calendar year basis. The lifetime benefit maximum is $500,000.

As of August 1990, Wisconsin's Office of the Commissioner of Insurance reports 464 HIRSP enrollees under age 19.

The current HIRSP plan administrator is Mutual of Omaha.

CHAMPUS/CHAMPVA

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a federal program created for the benefit of dependents of personnel serving in the uniformed services. The federal government maintains CHAMPUS not as an insurance program, but rather as a service-connected benefit. Hence, the sponsor (the person on active duty) is not covered under the CHAMPUS program; only dependents are covered. CHAMPUS will cover retired personnel and their dependents. Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) follows the CHAMPUS model and serves families of veterans with 100% service-connected disability or the survivors of a veteran who died as a result of a service-connected disability.

It is expected that CHAMPUS/CHAMPVA dependents will not seek civilian medical care except when such care is not available at a nearby military medical-care facility. Prior authorization for medical care in the civilian community is required if the sponsor lives within 40 miles of a military or public health-care facility.

Covered CHAMPUS services rendered at nonmilitary facilities are generally the same as those services covered by commercial medical insurance policies. Outpatient care is subject to a $50 fiscal year (October 1 to September 30) deductible per individual ($100 per family), then 75% coverage to a family out-of-pocket maximum of $1,000 for active-duty sponsors, $10,000 for all others. These out-of-pocket amounts only apply to CHAMPUS covered expenses. CHAMPUS enrollees are liable for "usual and customary" deductions taken on claims from those providers who do not accept CHAMPUS assignment-of-benefits.

CHAMPUS coverage is secondary to commercial health plans but primary over other governmental programs such as WMAP.

Fiscal agents for the CHAMPUS/CHAMPVA programs are chosen on a nationwide competitive basis. The current CHAMPUS fiscal agent for Wisconsin is the Uniformed Services Benefit Plan, Inc., administered by The Associated Group located in Columbus, Indiana.

Wisconsin Program for Children With Special Health Care Needs

The Bureau for Children With Physical Needs (BCPN) in the Wisconsin Department of Public Instruction, Division for Handicapped Children and Pupil Services, administers the Wisconsin Program for Children with Special Health Care Needs as mandated by PL 99.35, Title V of the Social Security Act, Sec. 2192(a).

This program serves children, birth to 21 years of age, with special health care needs, defined as children

- with disabilities and handicapping conditions
- with chronic illnesses and conditions
- with health-related educational or behavioral problems
- at-risk for disabilities, chronic conditions, and health-related educational and behavioral problems

Program staff work with public and private education, health, and social service agencies. A primary focus of the program is to provide consultation services to children, families, medical providers, school personnel, and other agencies.

Financial assistance for diagnosis and follow-up care for children whose families are financially eligible is available through the Wisconsin Program for Children with Special Health Care Needs. Families must file a confidential application provided to them by BCPN to determine their eligibility for treatment funds. BCPN must also give prior authorization for any health care service if it is requested to pay for such service. Local school districts are encouraged to refer children with special health care needs for consultation services and possible financial assistance for treatment costs.

Consultation Services

Consultation services are given relative to

- the health-related developmental, educational, and behavioral problems of children with chronic illnesses and disabling conditions.
- the management and coordination of the multiple health care systems involved in the treatment of this population.
- obtaining financial support from public and private resources such as Medicaid (Title XIX), Supplemental Security Income (SSI), and private insurance plans.
- the medical care needs of chronically ill and disabled children enrolled in the public and private school systems, institutions, and other child-caring agencies.
- standards of care and services.

Consultation services are provided by a multidisciplinary staff consisting of a pediatrician, nurse consultants, a physical therapy consultant, a medical social work consultant, audiology consultants, and health care financial consultants.

Financial Assistance for Treatment Costs

Limited financial assistance for diagnosis and follow-up care for children is available to families based on the following criteria:

- The family's income must fall within adjusted Federal Poverty Income Guidelines that are issued yearly.
- Health care services must be provided only with prior approval of BCPN staff.
- Medical care must be under the direction of a physician from the BCPN list of participating physicians.
- Professional personnel must be licensed and fully qualified.
- Facilities providing medical services (for example, hospitals, clinics, brace shops) must be approved by BCPN.
- Recipients recognize that program funds are secondary to available private insurance and/or WMAP coverage.

Services that may be covered through the Wisconsin Program for Children with Special Health Care Needs include:

- physician services
- nursing care (limited)
- physical therapy
- occupational therapy
- speech/Language therapy
- audiology services
- equipment such as crutches, walkers, wheelchairs, hearing aids, cardiorespiratory monitors, braces, and prostheses
- outpatient x-rays, laboratory, and diagnostic tests
- dental and orthodontic services for children with cleft lip and/or palate
- dental prophylaxis and topical fluoride treatment for children with cerebral palsy

- o medications
- o inpatient hospital services
- o outpatient hospital services
- o transportation to and from major treatment centers (limited)

To refer a child, please send the information to the Wisconsin Department of Public Instruction, Bureau for Children With Physical Needs, P.O. Box 7841, Madison, Wisconsin 53707-7841. (See the BCPN referral form in Appendix E.)

Private Commercial Plans

Private commercial plans can be separated by ownership type as stock or mutual companies (as defined in Chapter 611, Wis. Stats.) or as service insurance corporations (as defined in Chapter 613, Wis. Stats.). The legal distinctions are in part based on the company's tax status. Tax-exempt status for service insurance corporations is allowed dependent on the company's adherence to certain business practices and underwriting procedures (for example, open enrollment for individuals).

Nationwide, the most recognizable service type organization involves the Blue Cross-Blue Shield concept. Historically, there was a clear distinction between the "Blues" and "commercial" carriers. The Blue Cross-Blue Shield concept was based on the promise of provision of hospital/medical services as required by the patient. The insured person was described as a subscriber to Blue Cross-Blue Shield plans; the plans established contractual relationships with hospitals and doctors. If subscribers received services from non-member providers, the "Blues" indemnified the subscriber for the fee-for-service claims. Each of the states had operations franchised from the National Blue Cross Association.

In Wisconsin in the early 1980s, the "Blues" concept began to change. The distinct Blue Cross and Blue Shield plans combined to form Blue Cross-Blue Shield United of Wisconsin. In the late 1980s, Blue Cross-Blue Shield United of Wisconsin lost its tax-exempt status as it decided it had to change underwriting practices to remain competitive. In essence, Blue Cross-Blue Shield United of Wisconsin now operates as a commercial carrier.

Historically, the commercial carriers were life or property and casualty insurers who entered into the health insurance business as part of a marketing strategy to provide complete insurance packages for their customers. Generally, these insurers are classified as either a stock or a mutual company. A stock insurance company is organized for the purpose of making profits for its stockholders. A mutual insurance company is owned and organized by its policyholders. They issue no stock, however excess

earnings (premiums minus claim costs) are returned to the policyholders in the form of dividends. Commercial carriers primarily cover their insureds by reimbursing a percentage of fee-for-service claims.

Medical insurance can be purchased via group, versus individual, policies. Under group insurance, coverage is provided for a number of people through the use of a single contract/master policy. The individuals covered by the group insurance are not parties to the contract; the contractual relationship is between the insurer and the named policyholder (for example, the employer or labor union). Under an individual policy, the insured individual is the policyholder. Generally, group insurance coverage usually costs less and provides more comprehensive coverage than individual coveage because the "risk" absorbed by the insurer is less concentrated and its administrative costs can be spread over a greater number of persons.

There are three primary types of medical care insurance sold by commercial carriers: (1) basic hospital-medical-surgical, (2) major medical, and (3) comprehensive medical.

Basic coverage generally refers to services specifically enumerated as being covered at 100% (that is, first-dollar coverage) of charges up to specific limits based on frequency of service and/or usual and customary/relative-value rate schedules. Examples of basic coverage could be: (1) 180 days per illness per calendar year for hospital inpatient room and ancillary charges; (2) $30 per day for inpatient physician consultations; or (3) $250 per calendar year for outpatient diagnostic services.

Major medical coverage is designed to activate once the basic limits are met and to cover items not paid under the basic contract. If the basic benefits are the "floor," then the major medical coverage represents the "ceiling" on the policy. Major medical coverage usually is dependent on deductible and co-insurance provisions which require that the insured incur an out-of-pocket expense each calendar year either as a prelude to or in conjunction with the payment of major medical benefits. There is usually a lifetime maximum major medical benefit total, perhaps $250,000. Examples of major medical expenses could include: (1) outpatient diagnostic charges in excess of a $250 basic maximum, (2) physical therapy, or (3) prescription medications.

Some stand-alone basic contracts exist; however, most commercial plans that make the distinction provide major medical features to supplement basic coverage.

A comprehensive medical plan combines the aspects of both the basic and major medical concepts. It is an increasingly popular mode of coverage from the insurer's and, to a lesser extent, from the insured's perspective. The insurer saves money by reducing the administration costs in distinguishing between basic and major medical claims and by eliminating the "first-dollar" basic

benefit. The insured saves premium expenses in exchange for forgoing the 100% basic coverage. A common example of a comprehensive plan would be a $200 deductible followed by 80% coverage (or 20% co-insurance) of the next $4,000, followed by 100% coverage per individual-all on a calendar year basis applicable to covered services. In this example, the insured's liability would be $1,000 per person with perhaps a $3,000 family out-of-pocket limit.

Self-Insured (Funded) Plans

Some employers and employee groups (for example, labor unions) can achieve cost savings by assuming all or a portion of the risk for health benefits offered their employees/members. Some organizations have also demonstrated the ability to realize savings by processing health benefit claims and paying medical care providers directly. These situations of assumed risk and claims administration are usually referred to as "self-insurance"; however, a more expressive label would be "self-funded" or "self-administered."

An employer that performs these functions from within its own resources is not "insured," since there is no transfer of risk. The employer retains the potential for loss for all covered medical expenses incurred by the employees/members and dependents. An employer can transfer some of this risk by purchasing "re-insurance" or "stop-loss" coverage from a commercial carrier. For a premium, the commercial carrier will assume the covered medical expenses of an individual who has reached some stated threshold, perhaps $50,000 in medical expenses in any one policy year. The employer may also pay for commercial coverage, which reimburses the employer for medical expenses paid out in total, perhaps $1,000,000 for all covered employees.

There are three primary administrative options available to those entities who self-fund. Under an Administrative Services Only (ASO) arrangement, an insurance company provides for the actuarial and benefit design functions, claims processing, data retention and analysis, and stop-loss coverage. A third-party administrator (TPA) can provide all of the services of an ASO except, because it is not an insurance company, stop-loss protection. Self-administration means the employer/health and welfare plan performs the functions that would have been contracted out to a TPA.

The Employee Retirement Income Security Act (ERISA) prohibits individual states from considering self-insured/funded plans as insurance companies for regulation purposes.

Managed Care Alternatives

Alternative health care delivery systems can provide health and medical care services to voluntarily enrolled members in exchange for a fixed fee or premium. Managed care is a concept which integrates the insurance (financing) aspect with the medical/health care delivery and management function. Managed care is in contrast to the traditional system of medical care consumption in which the consumer obtains medical care from a variety of providers whose income increases directly with the number and complexity of services rendered.

Alternative delivery systems primarily follow either the Preferred Provider Organization (PPO) or the Health Maintenance Organization (HMO) models.

PPOs offer economic incentives to enrollees who select low-cost providers. Historically, PPOs tried to control costs by discounting provider's charges; however, most successful PPOs have found it necessary to adhere more closely to the managed-care model (that is, utilization management). PPOs are often associated with self-insured (funded) plans.

HMOs attempt to offer a competitively priced insurance product by controlling costs through utilization management and by controlling (employing) or contracting with selected referral providers. HMOs assume a contractual responsibility to provide or assure the delivery of a stated range of health services. HMO enrollees have a legal right to medical care provided by an HMO, in contrast to the traditional sector in which the medical care provider has a right to accept or not accept a particular patient.

HMOs accept voluntary enrollment of subscribers for a specified timeframe. An HMO must charge a fixed periodic premium independent of the quantity of services provided a particular enrollee. The implication is the HMO does not gain any substantial revenue by providing more services.

HMOs assume at least part of the financial risk and/or gain in providing medical services. This risk factor is thought to create an incentive for cost containment.

HMO members agree to see a primary-care physician who is either employed by or contracts with the HMO. The primary physician serves as the "gatekeeper" by providing routine medical care and initiating referrals to medical care specialists who may be employed outside the HMO.

An HMO is categorized or defined by the relationship between the organization, its physicians, and other providers.

- Staff Model - the HMO hires its own medical staff. Physicians are salaried and practice in HMO-owned or HMO-managed medical facilities.

- Group Model - the HMO contracts with one multi-specialty clinic. The physician is employed by or is a partner in the independent clinic. A clinic contracted with an HMO can serve non-HMO patients. The HMO pays the clinic, and the clinic in turn distributes these proceeds among the clinic's doctors.

- Individual Practice Association (IPA) Model - an IPA most closely resembles the fee-for-service provider. Physicians agree to a prearranged discount fee schedule for services provided each HMO enrollee assigned to them. An IPA will put its member physicians at risk for the financial success of the HMO organization. A portion of the physician's fees are retained in a pool, the proceeds of which are redistributed to member physicians based on their actual utilization patterns compared to projected standards.

- Network Model - a network HMO takes on some or all of the characteristics of each of the other three models.

(Appendix F includes data reported by the office of the Commissioner of Insurance on population percentages of HMO enrollments by county as well as a listing of HMOs licensed in Wisconsin as of January 1, 1990.)

Chapter 6

Documentation

Documentation, as it relates to access of third-party funds, is concerned with (1) the process of collecting insurance information, consent forms, and assignment-of-benefit declarations from the student's family, (2) the content of medical records, (3) the maintenance of effort, and (4) the summary and reporting of financial results. The first three items are discussed in this chapter, and the last item is discussed in Chapter 10.

Maintenance of Effort

Maintenance of effort is a demonstration of adherence to the policies and procedures enacted to ensure maximum third-party payments. Chapter 7 discusses the recording and transmission of treatment services data. The processes necessary to generate an insurance claim form are addressed in Chapter 8. Chapter 9 discusses the life-cycle of an insurance claim and illustrates the maintenance of individual student financial data in a quasi "patient accounts" system.

Medical Records

From a financial standpoint, medical records serve to provide proof of the medical necessity of related services provided to students. A general rule-of-thumb is that there should be a prescription by or orders from or approval of the attending physician for the services provided on which a claim is based.

The WMAP, which can serve as a proxy for the health care financing sector, stipulates that providers "who receive payment from WMAP must maintain records which fully document the basis of charges upon which all claims for payment are made." Medical records should identify the student/patient/recipient to whom or on whose behalf the service was provided, dates of service, the type (actual activities performed) and quantity (for example, hours of direct contact) of service, and the name of the person who actually provided the service. WMAP may audit providers at any time to ensure documentation of the medical necessity and appropriateness of services and adequate financial documentation.

Medical records are indeed notations related to the health of a patient prepared by or under the supervision of a health care provider. Entries into medical records should be legible, accurate, and concise but complete and objective.

Medical records maintained by an LEA should contain documentation of (1) student/patient assessments, (2) treatment plans and service delivery goals, (3) daily treatment notes and/or progress reports, (4) prescription renewal and other prior authorization efforts, (5) discharge summaries, and (6) special reports includ-

ing referrals and medical-related correspondence with/to other service agencies or programs.

Standards of physical security, access, confidentiality, and release of medical records should be comparable to and compatible with those standards imposed on patient health care records under s. 146.81-83, Wis. Stats.

Chapter 3 contained a discussion of the integration of medical records documentation for third-party access concerns with the documentation requirements of the special education system. The integration of these records systems is not only an efficient and effective approach, it also bolsters the concept that medical-related services provided via the school system should be viewed in the same context as similar services rendered in a clinical setting.

Communication With Student/Family

An LEA must address two primary concerns as it attempts to collect third-party funds. First, the LEA's action should be sanctioned through an informed written consent given by the family of the special education student. Second, the family must be given assurances that the LEA will correct any adverse financial situations that may arise because of the LEA's receipt of insurance proceeds.

The family initially might feel it is subject to an increased financial risk because the LEA's efforts might (1) cause insurance premiums to rise, (2) reduce available lifetime or periodic benefit maximums, or (3) result in deductible and coinsurance amounts to be paid by the family. It is not possible to provide absolute protection against an increase in premiums or even to prove that such an increase would happen solely because an insurance plan was made to pay out benefits on claims for medical services not previously filed. However, the LEA can provide protection against the other two possibilities.

Most insurance plans do have lifetime benefit maximums, but such maximums are rarely ever reached because (1) the maximum is set at a relatively high amount (for example, $500,000); (2) groups switch to insurance carriers that offer new plans, resetting the maximum benefit; or (3) many plans provide for reinstatement of a portion of the lifetime maximum used in any one fiscal period.

The question of deductible and co-insurance amounts can actually be turned around and used as a selling point. The LEA would indeed be absorbing such amounts applied to school-based claims, which could possibly increase benefits payable on medical expenses incurred by the student outside the school experience. For example, a policy might dictate an initial $100 deductible, followed by benefits payable at 80% of the next $2,000 in eligible expenses, followed by 100% coverage thereafter, all on a calendar-year basis. The $500 policy "out-of-pocket" maximum

could be satisfied with claims for charges filed by the LEA on the first 40 physical therapy sessions during the calendar year. Thus, acute-care expenses (not the LEA's responsibility) incurred later on in the year would be payable in full by the insurance plan.

A definite contingent liability exists for the LEA, and that is associated with the possible exhaustion of periodic benefit maximums. For example, some insurance plans will place a limit on the number of therapy treatments covered in a benefit period, although most plans will limit the number for each illness per period. Thus, an LEA might exhaust the available physical therapy benefits with school-based claims, leaving no benefits payable for an unexpected acute episode (for example, a broken arm).

The LEA should communicate with the family regarding their intention to "make whole" for the above-described acute-care claim. That is, if the acute therapy treatments cost $250 and if the insurance plan would have paid 80% of such charges, then the LEA must be prepared to reimburse the family $200. The family would be required to provide proof of the insurance plan rejection and proof of the family's payment(s) to the provider of the acute-care therapy. The LEA could very well set a time limit, perhaps one year after the expenses were incurred, for the family to provide proof of their financial loss.

(Appendix G contains illustrations of correspondences with families relating to LEA contacts with insurance plans.) The LEA should document that it has made at least an initial contact with the families of all students enrolled in special education. There should be no question that an LEA is singling out certain students (for example, WMAP recipients only) to the exclusion of others. Implicit in a LEA's decision to pursue third-party funds is the assumption that an effort will be made to tap <u>all sources</u>, both public and private.

Chapter 7

Collection and Transmission of Treatment Data

Diagnosis and Procedure Coding

Procedural coding systems were developed to standardize the communication of data regarding the treatment of patients by health care providers to third-party payers. Diagnostic coding was developed for medical records and statistical purposes, and is used to (1) track disease processes; (2) measure incidences of injury, mortality and illness; (3) classify medical procedures; (4) assist in medical research; and (5) evaluate appropriateness of patient care.

Third-party payers use coding systems for statistical purposes and for benefit determination. Most third-party payers process claims by means of computer programs that determine (1) whether the services (procedures) submitted are medically necessary for the treatment of the reported disorder (diagnosis); (2) if the services are a benefit of the insurance contract or government program; and (3) the amount of benefits payable for individual services, primarily as a fee-schedule rate or on a relative-value basis. For example, a claim submitted for physical therapy services would probably be rejected if the diagnosis was reported as diabetes mellitus. At the very least, the computer program would point this claim out as an exception and suggest that a review of the claim may be necessary.

Correct and maximum benefit payments are dependent on the accurate coding of insurance claims as to diagnoses and procedure data.

Diagnosis

All diagnostic coding should be based on the International Classification of Diseases, 9th Edition, Clinical Modification (abbreviated as either ICD-9-CM or ICD-9). The ICD-9-CM is published in three volumes:

Volume 1 - Diseases: Tabular List
Volume 2 - Diseases: Alphabetic Index
Volume 3 - Procedures: Tabular List and Alphabetic Index

The third volume is used for billing hospital claims; hence, an LEA would normally concern itself with Volumes 1 and 2.

ICD-9-CM is primarily a five-digit coding classification scheme. It is subdivided into 17 categories that broadly reflect etiology, disease location, periodicity, signs, symptoms, and other conditions. These 17 categories are partitioned into over

10,000 entries intended to describe the clinical picture of the patient. The categories are as follows:

Categories	1-13	Codes grouped by anatomical system
	14	Congenital anomalies
	15	Conditions originating in the prenatal period
	16	Symptoms, signs, and ill-defined conditions
	17	Injuries and poisonings

All diagnoses affecting the current treatment of the student/patient should be included on claim forms. Prompt and proper benefit payments depend on accurate, precise, and meaningful coding techniques. Claims filed by an LEA should use the primary diagnosis concept.

The primary diagnosis is the condition considered to be the major health problem for which the particular treatment is provided to the student/patient. The primary condition should always be listed first on a claim form. The claim form can accept up to three concurrent diagnoses. A concurrent diagnosis is a medical condition which has manifested itself at the same time as the primary condition and alters the treatment required or lengthens the expected recovery time of the primary condition.

Procedure

The Current Procedural Terminology, Fourth Edition (CPT-4), is a systematic listing and coding of procedures and services performed by or under the supervision/prescription of a physician. By default, CPT-4 became the procedural coding system of choice when, in 1985, the federal Health Care Financing Administration and the American Medical Association published the Health Care Financing Common Procedural Coding System (HCPCS), a national-level coding system for reporting health care services to the Medicare and Medicaid Programs. HCPCS is a three-level system developed to augment the already existing CPT-4 system.

- Level One Codes are CPT-4 codes, which are updated annually.
- Level Two Codes are nationwide codes used for more definitive reporting of physicians' services than is available through CPT-4. They are also used for reporting nonphysician/allied health professional services such as transportation, durable medical equipment, and dental procedures.
- Level Three Codes are locally assigned and used by Medicare's fiscal intermediaries and the Wisconsin Medical Assistance Program.

Under CPT-4, each procedure or service is identified by a five-digit code. The provider of service should select the procedure or service code that most accurately identifies the services performed. Nationally assigned codes are five characters (alphanumeric) and begin with any of the alpha characters A through V.

Locally assigned codes are five characters (alphanumeric) and begin with the alpha characters W through Z.

HCPCS codes and their narrative descriptions are required on claims to the Wisconsin Medical Assistance Program. Each provider type (for example, physical therapist, speech pathologist) has certain procedure codes allowed or assigned by WMAP; the range of these codes can be more restrictive than allowed under CPT-4.

The Third-Party Specialist

In a health care setting, the third-party specialist must be fluent in medical terminology. This person is often asked to abstract data from a patient's medical record to complete the procedure and diagnosis-code sections of the insurance claim form. Most third-party programs require that these claim forms have provider attestation to the accuracy of procedural and diagnostic representations, but very often these assurances are given without actual proofreading of the claim by the hands-on provider. Thus, great faith is placed in the insurance specialist to produce an accurate representation of services provided.

An insurance specialist should never:

- change information as it is stated in the patient's legal medical record.
- code a diagnosis to an insurance claim that has not first been entered into the medical record by the health care provider.
- add a procedure to a claim that is not recorded or otherwise documented elsewhere.

Procedure and diagnosis coding is a very precise process which requires an in-depth understanding of medical terminology, in general, and clinical procedures, in particular. The LEA should take care to assign third-party activities to employees or contractees with sufficient experience in the medical arena. It should be the responsibility of the claims processor to accurately report procedure and diagnosis information to the third-party payer. However, it should be the responsibility of the attending physician or therapeutic specialist to actually assign a diagnosis to a student/patient or a procedure code to the service provided.

The LEA should establish a system whereby this medical-related information is generated and transmitted in the most efficient mode possible. The goal should be to maximize third-party payments; however, the process should not detract from or hinder the actual provision of medical/therapy service for the student.

Whatever system is used to produce an actual claim form for submission to a third-party payer, certain data items must be

known to the LEA's business office, its contractees, or its contracted third-party administrator (TPA). The process of obtaining insurance plan-specific details from the student's family has been addressed previously in this guide. The LEA's business office should already have student specific data such as date of birth and identified diagnosis obtained from the IEP or other school documents. What's left is the transmittal of procedure-specific and newly documented diagnostic information from the hands-on provider to the LEA business office.

Transmission of Procedure Data

During this stage in the process, the hands-on provider does not need to know any financial-related details for an individual student, such as eligibility for potential third-party funds recovery. At other stages, the provider has to be involved in the financial process, for example the completion of WMAP prior authorization requests. At this point though, the provider only needs to understand the definition of a "billable" service and be responsible for maintaining the student's medical record.

The provider should be asked to document special education and related services rendered to all EEN students, not just for those identified by the business office at the beginning of a period as having potential for third-party claims. This is necessary because WMAP eligibility is often granted on a retroactive basis, sometimes many months, occasionally more than one year after the fact. Another situation would involve delays in obtaining insurance plan information and consent from the student's family. If the LEA did not document services during these interim periods, then they would lose out on third-party funds for past services.

By documenting special education and related services in the same manner for all EEN students, the LEA further demonstrates that it is not singling out any particular student subset (for example, WMAP recipients) for unique purposes.

What follows is one interpretation or systems example on how an LEA could capture medical intervention data for billing purposes. **(Note: Documentation for billing may not be sufficient for that required for medical records purposes.)** This data collection stage involves the observation of transaction data (that is, "billable" services) and the completion of an initial record of that transaction on a preprinted, sequentially prenumbered source document. The business office prepares and distributes a "blank" source document for each student who receives special education-related services for a single time period from each hands-on provider. The provider records the type of service, date of service, and amount of treatment time (units) and confirms an already-stated diagnosis (or documents another condition). At the end of the period, the providers return the source documents to the business office. Now the business office has all the data required to generate an insurance claim form.

In this financial system, a treatment unit is defined as each 15-minute segment of the provision of WMAP covered services. To illustrate, the WMAP Provider Handbook, Part P-Division I-Section II, dated July 1984, defines covered occupational therapy services as those medically necessary, physician-prescribed services performed by a certified occupational therapist or by a occupational therapy assistant (OTA) under the direct and immediate on-premises supervision of a certified occupational therapist. A February 17, 1986, WMAP bulletin refers to the reimbursable nature of services provided by occupational therapy students during practicums, subject to various limitations.

The WMAP defines occupational therapy procedures to be treatment (with or without equipment or apparatus) which requires the personal, continuous attendance of a registered occupational therapist, OTA, or student occupational therapist.

The WMAP defines a treatment unit, for reimbursement purposes, to include the time spent in both direct treatment as well as limited-preparation activities related to the recipient's individual treatment. Such activities as preparing the patient for treatment, preparing the treatment area, and preparing the patient for return are considered to be within the unit of treatment.

Activities not associated with treatment are not considered part of the time for which benefits are payable. Such noncovered activities include but are not limited to (1) end-of-day cleanup of the treatment area (2) preparation time for group therapy sessions (3) consultations with family members and teachers, or (4) completion of documents such as the "source documents" used for insurance claim purposes.

WMAP expects a prospective claimant to be well-schooled in the rules, regulations, definitions, and the like for filing claims to their fiscal intermediary. The means to such understanding is provided by the WMAP in provider-specific handbooks and periodic bulletins. Once the school district and/or its agent is completely familiar with the requirements for accessing health care financing, they can design the source documents necessary for claims processing. There are, of course, as many different format options as there are varied needs and technological capabilities for data collection across school districts.

A sample illustration of a source document meant to capture claim related data on occupational therapy services appears at the end of this chapter. It is a one-sheet, two-sided document. The top part of side one is completed by the business office; then the document is transferred to the therapist. The therapist would be expected to record the transaction data and return it to the business office at the end of the period. Appropriate security measures should be in place to protect the document while it is in the therapist's possession. A lost document would require a

time-consuming reconstructive effort via abstract from the medical/treatment record.

In this sample system, each provider is given a school district-specific four-digit number. The first digit signifies to the business office which third-party payer(s) can be billed (for example, 0 = no third-party, 1 = all third-parties, 2 = private insurance only). The last three digits correlates to the specific provider's name. To illustrate, WMAP will pay for physical therapist assistant and occupational therapy assistant services under qualified circumstances. It is unlikely however, that therapy assistant's services would be covered by a private insurance plan.

The service codes used in this system identify those procedures recognized by WMAP as related to covered occupational therapy services. The directions on side two relating to how treatment services should be recorded for use in the eventual filing of third-party claims should be self-explanatory.

Occupational Therapy Census

For Month of: *Check One*						Year
☐ January	☐ March	☐ May	☐ July	☐ September	☐ November	19 _____
☐ February	☐ April	☐ June	☐ August	☐ October	☐ December	

Provider Name	Student Name	Location

Provider WMAP Number	Student Control Number

Provider Code Number(s)	ICD-9-CM Number(s)	Description
a)	1)	
b)	2)	
	3)	

Date	Service	Unit(s)	Adjustment	Date	Service	Unit(s)	Adjustment	Date	Service	Unit(s)	Adjustment
1				11				21			
2				12				22			
3				13				23			
4				14				24			
5				15				25			
6				16				26			
7				17				27			
8				18				28			
9				19				29			
10				20				30			
								31			

Therapist's Signature ➤	Date	*For Business Office Use*		
		OT Units Rate x =	COTA Rate Units x =	TOTAL

GUIDELINES FOR COMPLETION OF TREATMENT CENSUS FORM

Service: For each date of service and for each separate procedure on any single date, select the most appropriate code from the list below and enter under the Service column. Slots are available for up to three district procedures for each date of service. Do not enter codes marked.*

Unit: For each separate service enter the total "billable" time expressed in units:

A unit equals 15 minutes. "Billable" time is that defined by the WMAP for preparation of and actual hands-on treatment. Preparation time is not "billable" for group services.

Adjust: The Adjustment column is to be used for these circumstances. If there are no entries in the Adjustment column for a particular service, then it will be assumed that services were rendered by the provider at the location and related to the ICD-9-CM code(s) entered in the "header" section on the front side of this form. Adjustment options include:

Location: If place of service is different than that already noted, then choose the appropriate code from the list noted below.

Provider: If the hands-on provider was not the person already noted, then enter the provider code number in a) and/or b) in the "header" section, then enter a or b in the appropriate slot in the Adjustment column.

ICD-9-CM: The diagnosis code(s) already listed will be those used to support a third-party claim; the primary diagnosis is listed #1). If the primary diagnosis for a particular service is different than #1), then choose and enter either 2 or 3 in the Adjustment column. If none of the listed diagnoses is applicable, then enter the appropriate ICD-9-CM code number in the Adjustment column.

Non-EEN Service: If the service provided was not in relation to the student's EEN needs as identified in the IEP, then enter "non EEN" in the Adjustment column.

OCCUPATIONAL THERAPY CODES

Ind	Group	
100		Evaluation/Re-evaluation
*110		Motor Skills
111		Range of Motion
112		Gross/Fine Coordination
113		Strengthening
114		Endurance/Tolerance
115		Balance
*120	*220	Sensory Integrative Skills
121	221	Reflex/Sensory Status
122	222	Body Concept
123	223	Visual-Spatial Relationships
124	224	Posture and Body Integration
125	225	Sensorimotor Integration
*130		Cognitive Skills
131		Orientation
131		Attention Span
132		Problem Solving
133		Conceptualization
134		Integration of Learning

Ind	Group	
*140		Activities of Daily Living Skills
141		Self-Care
142		Work Skills
143		Avocational Skills
*150	*250	Social Interpersonal Skills
151	251	Dyadic Interaction Skills
152	252	Group Interaction Skills
*160	*260	Psychological Intrapersonal Skills
161	261	Self-Identity and Self-Concept
162	262	Coping Skills
163	263	Independent Living Skills
*170		Preventive Skills
171		Energy Conservation
172		Joint Protection
173		Edema Control
174		Positioning
*180		Therapeutic Adaptations
181		Orthotics/Splinting
182		Prosthetics
183		Assistive/Adaptive Equipment
184		Environmental Adaptations

LOCATION CODES

S	School Premises
OP (H)	Outpatient Hospital Facility
OP (R)	Outpatient Rehabilitation Agency Facility
OP (M)	Outpatient Medical Facility
H	Student's Home

Call _____ at _____ if you have any questions regarding the completion of this census form.

Chapter 8

Insurance Claim Form Preparation

After permission has been obtained from the student's family, and services have been rendered and documented, and such documentation has been transmitted to the business operation, then the LEA, its contractees, or its third-party administrator can proceed with those activities which should result in benefit payments from a third-party.

The business office must first decide which third-party should be billed. If the student is covered only by a private plan, then the LEA will file only to the private plan. If the student is covered only by WMAP, then the LEA will file a claim to WMAP's fiscal intermediary. If the student is covered by both a private plan and WMAP, then the LEA must decide the proper filing sequence.

WMAP is indeed secondary to private insurance plans; however, WMAP requires providers to file private claims first only for those services and under those circumstances described in Section IX-D and Appendix 18 of the WMAP Provider Handbook, Part A. For example, an LEA is not required to file a private insurance claim before filing a WMAP claim if the student is covered by a Time Insurance plan and the services claimed are physical and occupational therapy. The LEA could file its claim to WMAP only and receive WMAP's payment rate, an amount which may be substantially less than the actual charge. WMAP will then generate a corresponding claim and file it to Time Insurance, with a statutorily backed demand for Time to pay the available private plan benefits to WMAP. The charge on the WMAP-generated claim will be their payment amount to the LEA, not the original charge billed by the LEA.

The LEA's decision question is, Should it only file a claim to and accept WMAP's reimbursement rate or should it first file a Time Insurance claim with the expectation of receiving greater benefits from the private plan. If the LEA files a Time claim and receives payment in an amount less than the WMAP reimbursement rate (perhaps some of the charges were applied to the Time policy deductible), then the LEA could file a "secondary" claim to the WMAP and expect to receive benefits totaling the WMAP rate minus the Time Insurance benefit amount.

Claim Form Procedure Codes

In any event, the service code captured on the provider-generated census form will have to be transformed to a procedure code acceptable to insurance plans and WMAP. Claims filed to private insurance plans should use the Level One (CPT-4) subset of the HCPCS system. Claims to WMAP should use the applicable HCPCS Level Two or Three procedure code(s). What follows is an illus-

tration of how the aforementioned (see Chapter 7, Transmission of Procedure Data) LEA-specific occupational service codes could be transformed into corresponding HCPCS procedure codes and descriptors which would be entered on the claim form.

District Code	HCPCS		Descriptor
	Private	WMAP	
100	97799	W9509	OT Eval
111-115	97110	W9523	Motor Skills
121-125	97114	W9525	Sens. Integr. Skls.
131-135	97139	W9527	Cog. Skls.
141-143	97540	W9525	ADL
151-152	97114	W9520	Soc. Interper. Skls.
161-163	97114	W9520	Psych. Intraper Skls.
171-174	97139	W9531	Prevent. Skls.
181-182	97500	W9533	Therap. Adapt.
183-184	97114	W9533	Therap. Adapt.
221-225	97114	W9512	Gr. Sens. Interg. Skls.
251-252	97114	W9522	Gr. Soc. Interper. Skls.
261-263	97114	W9522	Gr. Psych. Intraper. Skls.

Claim Form Rate Schedule

The LEA must determine a charge for each service type to be billed to the third-party. The charges billed across plans should be the same; that is, a charge rate billed to Time Insurance should be the same as that billed for the same service to WMAP. What is an appropriate charge rate?

In the private sector, a provider's schedule of charges should reflect some relation to its costs to provide the service. A private provider might justify its charges as follows: There are fixed costs to recover and variable costs which are incurred in proportion to the volume of services provided. Costs are classified as direct (for example, a therapist's salary) or indirect (for example, assigned overhead). A profit factor and an allowance for estimated unreimbursed charges are added to the estimated costs, resulting in gross revenue requirements. The amount of

projected services to be provided are calculated on a weighted average treatment unit basis. Estimated gross revenue is divided by the projected total treatment units to arrive at the amount charged to the patient per unit of service.

In reality, however, the "accounting-defined" charge level is probably adjusted to take into account what the market will bear or what the competition charges.

The LEA's perspective regarding charge rates billed to third-parties should be different from that of the private provider. An LEA has no profit margin to maintain and no allowance for uncollectible charges to students. In fact, no charges are to be billed to the student's family, only rates to be billed to the third-party.

What would be an appropriate compromise regarding charge rates for related services rendered special education students? Here are two viable options. First, the LEA could canvass the local private market, calculate an average of what private providers are charging for the various services, then deduct a "profit" factor to arrive at a rate to be billed to third-parties. Otherwise, if the LEA contracts with a particular provider to render the majority of a particular type of service, it could use the contractual reimbursement rate as a proxy for the value of services provided by LEA employees. Whatever rates are chosen, they should be uniformily billed across all third-party plans, both public and private.

Treatment data and charge information flows from the LEA to the third-party payer via the claim form.

The Claim Form

Most private insurance companies will accept a claim in the format of a letterhead statement form which indicates patient identifiers, date(s) of service, type(s) of service, and applicable charges. However, WMAP and CHAMPUS require the use of the HCFA 1500 claim form. Almost all private insurance and self-funded plans will accept the HCFA 1500 as "proof of loss"; however, these plans might also require periodic completion by the policyholder of their company-specific claim documents to initiate a claim cycle for a particular benefit period. Actually, as of July 1990, WMAP uses six different claim forms. (See Appendix H for illustrations of those forms which might be of interest to an LEA, including Drug, for disposable supplies; HealthCheck, for EPSDT/HealthCheck screening services; and the UB82, for any claims billed directly to WMAP by hospitals which contract with the LEA to perform services on hospital premises.)

Most third-party payers eventually will process claims using computer-related technology such as optical scanners to extract data entries from claim forms. Thus, we recommend that LEAs file claims to all third-party payers using the standard, national

HCFA 1500 form, except for those WMAP-specific cases previously cited.

The following pages illustrate samples of appropriate paper claims to (1) a private insurance plan and (2) WMAP for occupational therapy services rendered by an LEA employee on school premises. Appendix I contains general instructions for the completion of HCFA 1500 paper claims to private plans and WMAP.

Time Insurance
P.O. Box 624
Milwaukee, WI 53203

FORM APPROVED
OMB NO. 0938-0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

[ ] MEDICARE (MEDICARE NO.) [ ] MEDICAID (MEDICAID NO.) [ ] CHAMPUS (SPONSOR'S SSN) [ ] CHAMPVA (VA FILE NO.) [ ] FECA BLACK LUNG (SSN) [X] OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Student, Iam A.
2. PATIENT'S DATE OF BIRTH: 10 | 03 | 83
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Student, Iwas A.
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 1795 Pine Street, Four Lakes, WI 54740
   TELEPHONE NO.: (608) 267-9999
5. PATIENT'S SEX: MALE [X] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS): 123
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]
8. INSURED'S GROUP NO. (FOR GROUP NAME OR FECA CLAIM NO.): 98765
   [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (LIST NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): None
10. WAS CONDITION RELATED TO:
    A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
    B. ACCIDENT: AUTO [ ] OTHER [X]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): same
    TELEPHONE NO.:
    11a. CHAMPUS SPONSOR'S STATUS: ACTIVE DUTY [ ] RETIRED [ ] DECEASED [ ] BRANCH OF SERVICE:
12. PATIENT'S (OR AUTHORIZED PERSON'S) SIGNATURE (READ BACK BEFORE SIGNING): I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
    SIGNED: Signature on file DATE:
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
    Signature on file
    SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP):
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION:
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES:
16a. IF EMERGENCY CHECK HERE [ ]
17. DATE PATIENT ABLE TO RETURN TO WORK:
18. DATES OF TOTAL DISABILITY: FROM THROUGH
    DATES OF PARTIAL DISABILITY: FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): IEP
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE):
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [X] CHARGES:
23. A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR I.D. CODE)
    1. 343.20 Infantile cerebral palsy--quadraplegic
    2.
    3.
    4.
    B. EPSDT YES [ ] NO [ ]; FAMILY PLANNING YES [ ] NO [ ]; PRIOR AUTHORIZATION NO:

24 A DATE OF SERVICE FROM	TO	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* TOS	H LEAVE BLANK
				Occupational Therapy					
030990	031090	0	97110	Motor Skills - 60"	1	60 00	4	1	
				(Sue Miller, OTR)					

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.): C. F. Cooper, Administrator
    DATE: 11/1/90
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK): YES [ ] NO [ ]
27. TOTAL CHARGE: 60 00
28. AMOUNT PAID:
29. BALANCE DUE: 60.00
30. YOUR SOCIAL SECURITY NO.:
31. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.: Blue Lake School District, P.O. Box 1001, Four Lakes, WI 54740, (608) 269-1111
    I.D. NO.
32. YOUR PATIENT'S ACCOUNT NO.:
33. YOUR EMPLOYER I.D. NO.: 39-9988776

* PLACE OF SERVICE AND TYPE OF SERVICE (U.S.) CODES ON THE BACK
REMARKS

AC 306 (1-89)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 3, 6, 7, 8, 9 and 11.

BLACK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered a 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR.422 510)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION.

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - - Ambulance
0 - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - (ASC) - Ambulatory Surgical Center
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility
E - (COR) - Comprehensive Outpatient Rehabilitation Facility
F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
F - Ambulatory Surgical Center
H - Hospice
L - Renal Supplies in the Home
M - Alternate Payment for Maintenance Dialysis
N - Kidney Donor
V - Pneumococcal Vaccine
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

BEST COPY AVAILABLE

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ CHAMPUS ☐ MEDICARE ☐ CHAMPVA ☐ FECA BLACK LUNG ☐ OTHER

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Student, Iam A.

2. PATIENT'S DATE OF BIRTH: 10 | 03 | 83

3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL):

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 1795 Pine Street, Four Lakes, WI 54740

5. PATIENT'S SEX: MALE [X] FEMALE [ ]

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS): 3999936920

7. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]

8. INSURED'S GROUP NO. (OR GROUP NAME, IF FILING A CLAIM NOW): ☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (IF KNOWN, PLEASE NAME BELOW FOR PATIENT AND/OR SPOUSE AND DEPENDENTS. INCLUDE POLICY AND/OR GROUP NUMBERS):

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT: YES [ ] [X] NO
B. ACCIDENT: AUTO [ ] [X] OTHER

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE):
TELEPHONE NO.

11a. CHAMPUS SPONSOR'S STATUS: ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED — BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.
SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.
SIGNED:

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP):

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION:

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE DATES:

16a. IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK:

18. DATES OF TOTAL DISABILITY: FROM THROUGH

DATES OF PARTIAL DISABILITY: FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): IEP

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE):

22. WAS LAB WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23. A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. (MAX. FOUR CODE)
1
2
3
4

EPSDT: YES ☐ [X] NO
FAMILY PLANNING: YES ☐ [X] NO

PRIOR AUTHORIZATION NO: 7654321

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C TYPE OF SERVICE (EMERGENCY)	PROCEDURES, SERVICES OR SUPPLIES (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G E.P.S.D.T. FAM. PLAN	H LEAVE BLANK
				Occupational Therapy					
030990	031090	0	W9523	Motor Skills - 60"	1	60 00	2	1	
				(Sue Miller, OTR 87654321)					

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)
C. F. Cooper, Administrator
DATE: 11/1/90

26. PATIENT'S ACCT. NO.:

28. ACCEPT ASSIGNMENT? (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐

29. TOTAL CHARGE: 60 00

30. AMOUNT PAID: 0 00

31. BALANCE DUE: 60.00

30. YOUR SOCIAL SECURITY NO.:

31. YOUR EMPLOYER I.D. NO.: 39-9988776

32. PHYSICIAN'S, SUPPLIER'S AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.:
Blue Lake School District
P.O. Box 1001
Four Lakes, WI 54740
(608) 269-1111
I.D. NO. 12345678

* PLACE OF SERVICE AND TYPE OF SERVICE CODES ON THE BACK REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form CHAMPUS-501 Form OWCP-1500 Form RRB-1500

BEST COPY AVAILABLE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 3, 6, 7, 8, 9 and 11.

BLACK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered a 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION.

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

1 - (IH) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - - Ambulance
0 - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - (ASC) - Ambulatory Surgical Center
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility
E - (COR) - Comprehensive Outpatient Rehabilitation Facility
F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
F - Ambulatory Surgical Center
H - Hospice
L - Renal Supplies in the Home
M - Alternate Payment for Maintenance Dialysis
N - Kidney Donor
V - Pneumococcal Vaccine
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

Electronic Claims

E.D.S Federal Corporation, WMAP's fiscal intermediary, offers providers the option of filing "paperless claims" with electronic claims submission. The following page contains an illustration of the data-input screen for therapy in the EDS software. As might be expected, an electronic claim form contains essentially the same data items as contained in a paper claim. The difference is the transmission of the claim to E.D.S either via magnetic tape, cassette, or telephone transmission.

Welcome to Electronic Claims Submission
EDS-Wisconsin Medicaid

BP NBR _____ L NAME _____ F NAME _____ MID _____

PCN _____ OI ___ TPL ___ MSC ___ EPSDT ___ FP ___ PA NBR _____

RP NBR _____ FP NBR _____ OP NBR _____

DIAG 1_____ 2_____ 3_____ 4_____ 5_____

DTL	FDOS	A1A2A3	POS	PROC	MOD	PP NBR	DX	CHARGE	UNIT	TOS	EMG
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

TOT BILL _____ OI PAID _____ PAT PAID _____ NET BILL _____

HCFA 1500 Item No.	EDS ECS-Code	DESCRIPTION
31	BP NBR	Billing provider No.
1	L Name	Last name of student/patient
1	F Name	First name of student/patient
6	MID	Medicaid ID No.
32	PCN	Patient control No. (i.e., provider's patient No.)
9	OI	Other insurance
10 (A & B)	TPL	Third party liability (W = workman's comp., A = auto, O = other)
11	MSC	Medicare status code
23 (B)	EPSDT	HealthCheck
23 (B)	FP	Family Planning
23 (B)	PA NBR	Prior authorization No.
19	RP NBR	Referring physician provider No.
21	FP NBR	Facility Provider No.
24 (C)	OP NBR	Other provider (Note: This entry is for the supervising therapist, see PP NBR)
23 (A)	DIAG	Diagnosis; ICD-9-CM
24 (A)	FDOS	From date of service
24 (A)	AI A2 A3	2nd, 3rd, 4th DOS for same type of service, in the same month, etc.
24 (B)	POS	Place of service
24 (C)	PROC	HCPCS procedure code No.
24 (C)	MOD	Modifier (Not required for PT/OT or Speech Pathology)
24 (C)	PP NBR	Performing provider No. (Note: if this entry is for a therapy assistant, then you must have an entry in "OP NBR")
24 (D)	DX	Related diagnosis; choose 1, 2, 3, or 4 from DIAG
24 (E)	CHARGE	
24 (F)	UNIT	No. of treatment units
24 (G)	TOS	Type of Service
16 (a)	EMG	Emergency
27	TOT BILL	Total bill
28	OI PAID	Other insurance paid
24 (H)	PAT PAID	Patient paid (Not of concern to LEA, refers to family liability associated with "deductible" aspect of WMAP application.)
29	NET BILL	

FRSMEFA1

Chapter 9

The Life Cycle of an Insurance Claim

Once the HCFA 1500 is generated and checked for accuracy, it should be transmitted to the applicable claims office/fiscal intermediary of the insurance plan or government program. Timely filing of claims is mandatory, since third-party payers generally require claims to be filed within one year of the date of service. (Appendix J lists some third-party claims office addresses and phone numbers. An LEA should develop its own directory of those companies and contact persons with which it conducts substantial claims activity.)

Under ideal circumstances, the claims office will settle the claim within three to six weeks. WMAP's contract with its fiscal intermediary requires maximum processing periods for "clean" claims. S. 628.46, Wis. Stats., stipulates that an insurer must pay/process valid claims within 30 days. Appropriate benefit amounts not paid within 30 days are subject to overdue payments which should include simple interest at the rate of 12% per year. As a public program, WMAP does not pay interest. In practice it is the insurer who determines if it has all the necessary information to classify the claim as valid. Hence, in practice this is a statute that is not vigorously enforced. However, some insurers recognize their liability under this statute, thus some companies routinely pay interest on claims not processed within 30 days of their arrival at the claims office.

With an assignment-of-benefits, the LEA should be paid the appropriate insurance proceeds. Most plans will enclose an explanation of benefits (EOB) to explain the calculations involved in the claim process. (Appendix K presents some examples of EOBs. Note the difference in the informational content among the examples. This supports the notion that in the real world of third-party financing, all is not ideal; differences exist in organizational philosophy and culture which translate into varying degrees of consumer orientation and customer service.)

If the generation of the HCFA 1500 is the "science" of claims activity, then the follow-up with third-party payers is the "art" of claims activity. Follow-up with the third-party payer is required when (1) it is necessary to respond to their requests for clarification or additional information, (2) an inordinate period of time has elapsed after the claim is filed without a response, and/or (3) the response from the third-party is inadequate.

Most inquiries from third-party payers will be technical in nature (for example, questions regarding an incomplete or inaccurate claim form). At other times, the requests might deal with a need for additional medical records to document or support the claim.

It is only through practice, through trial and error that LEA's insurance representatives can become proficient in the effective and efficient follow-up process with their third-party counterparts. Necessary attributes include knowledge of insurance terminology, claims processing methods across plans, and benefit structures of private and public plans.

An insurance representative must learn how to diagnose the peculiar aspects of each problem claim. When is it best to contact the insurer in writing or to make a phone contact? Most situations regarding problem claims to private plans can be settled over the telephone with the insurance plan's adjuster. However, follow-up on WMAP claims should be handled by writing the fiscal intermediary.

A medical care provider will file private insurance claims and receive insurance benefits on behalf of their patients. These providers aren't necessarily concerned as to the amount or correctness of the private insurance payment, because the provider knows it can seek any remaining balance due from the private-pay patient. Under these circumstances, it is the patient/insured who is responsible to ascertain the appropriateness of the insurance payments.

For school-based claims, however, by definition no patient liability exists. Hence, it is the responsibility of the LEA's insurance representative to audit insurance claim payments to verify that the maximum benefits have been paid.

In a medical care setting, a patient accounts system contains most of the necessary data items for input into the third-party claim process and serves as a functional control mechanism, both on an individual patient and an organizationwide basis. This system documents individual transactions and provides summary detail.

An LEA can set up an analogous student account system to assist in the managerial control function. It can be used to evaluate satisfaction of end goals, perhaps effective maximization of third-party payments. It can assist in the satisfaction of means goals, perhaps efficient completion of insurance claim forms.

The student's financial account is not a reflection of liability; rather, it is a repository of information. Such information, stored electronically and in paper form, might include (1) current policy details or requirements of third-party plans covering the student, (2) postings from provider treatment census forms to reflect summary details of frequency and type(s) of service, and/or (3) entries to reflect the sequence of claim submissions and the amounts received from third-party payers.

A properly implemented and maintained "related-service" financial account system can provide the necessary details to respond to

individual family inquiries regarding the LEA's access of their insurance plans. It can also provide input into the process whereby the LEA reports summary financial information to the Department of Public Instruction.

Chapter 10

Reporting Third-Party Payments

State Aid Treatment

Third-party payments are deductible receipts in the equalization aid formula. They are not deducted as an offsetting receipt to aidable EEN costs in the computation of state categorical handicapped aids.

Reporting Requirements

Third-party payment receipts are recorded as revenues in Source Code 964 (Insurance) on the Annual Report. To distinguish revenues recorded under this source code as applicable to EEN, a breakdown of receipts recorded under this source code is required. The amount of third-party payment receipts applicable to aidable EEN costs are reported in the Addendum Section of the Annual Report under the line entitled "Third-Party Insurance Payments for EEN Programs."

Audit

The amounts reported as third-party payment will be checked against the total reported in Source Code 964. If the third-party payment amount exceeds the amount reported in Source Code 964, the district will be asked for an explanation. Third-party payment receipts are reported in the annual reports and, like all other accounting transactions, are subject to local audit review. Documentation should be maintained to identify EEN third-party receipts as applicable.

Chapter 11

The Make or Buy Decision

An LEA will take into account many considerations as it decides whether or not to seek supplemental third-party funds. A primary consideration should be the mechanism whereby this effort will proceed. Options include (1) direct LEA claims processing; (2) cooperative efforts among LEAs, perhaps through a cooperative educational services agency (CESA); (3) contracting out such duties to a medical institution; or (4) a contract with a billing agent, or third-party administrator. Each LEA should examine its own peculiar circumstances. A mechanism chosen by one LEA may not be appropriate or viable for another LEA, even if they have similar student population demographics.

Third-party activity can be complex and time consuming. An LEA that wants to maintain all such activity in-house may not be able to count on existing staff to perform such duties. Third-party activity will require adaptations of and place additional demands on existing computer operations. Third-party activity should be coordinated with service delivery and with LEA business operations and should not detract from all of the other important LEA functions. Existing staff may not have the expertise necessary to operate effectively in the health care financing sector. Certainly, existing nonmanagerial staff can be trained to perform health-related business duties; however, unless an LEA has available human resources, it will find it necessary to hire additional business office staff to keep third-party activity in-house.

Given these constraints, why might an LEA decide to maintain all third-party activity in-house? The answer relates to a standard management activity-control. An in-house operation means all contact with families will be by school personnel. This public relations aspect should not be overlooked; after all, family cooperation is paramount. Without parental consent, there should be no contact with third-party payers.

An LEA can consider contracting out third party-related data processing needs to a service bureau or a time-sharing vendor. The primary difference between the two has to do with access. Service bureaus provide data processing services through batch processing on their own equipment. Input data and output information requires the physical transporting of source documents and output reports. A time-sharing vendor provides access to a central computer and online file storage to users who gain access via remote terminals and telecommunications devices.

The service bureau/time-sharing option can provide standard documents, which are returned to the system for further processing, or reports, which become formal presentations of information

in summary form. These entities also can provide some file-maintenance duties such as data storage and update of stored data.

The primary advantage to a time-sharing vendor service is its real-time capability to improve efficiency of user operations. Both systems afford cost savings via the sharing of a central computer; however, time-sharing is relatively more expensive because of the costs associated with data transmission.

A primary drawback to the service bureau/time-sharing option is its effect on data security and control. The LEA must assure itself that proper security measures are in place to protect the confidentiality of student/patient records. Also, this option would not relieve the LEA of those activities associated with data collection and refinement and the time-consuming actions of actual contact with the third-party payers.

The second option, a cooperative arrangement among LEAs would reduce start-up costs and ongoing administrative expenses. However, such an arrangement would require consistency across districts as to documentation standards, modes of treatment/service delivery, and, most important, a general agreement of the relative value assigned to the concept of access to third-party funds.

The third option available to LEAs is direct contracting with medical providers to perform third-party claims activity for all students/patients, not just those who receive their "related service" from these non-LEA employees. After all, these medical institutions already have systems in place for third-party collection for their private patients.

LEA costs associated with a service bureau or time-sharing company are a function of the time consumed in using these outside computer facilities. On the other hand, a medical service provider that also acts as a billing agent would probably ask to keep a per-transaction fee in addition to a guaranteed base-level reimbursement of medical services provided the student. Such an arrangement would not relieve the LEA of its responsibility to the student's family to ensure no out-of-pocket costs to the family. It could prove cumbersome for the provider to have to maintain corollary records for the student/patient.

The fourth option would have an LEA contract with a third-party management company or administrator to perform all third party-related functions. A third-party management company may provide a number of functions for school districts including:

- training for parents and local education personnel on what third-party billing is, what its legal basis is, and what it means to the LEA as a stakeholder?

- offering a computerized billing service for the filing and processing of third-party insurance claims.

- training to school district "practitioners" (therapists and teachers) on how to document services provided in order to be eligible for reimbursement.

- supplying all forms necessary to obtain third-party reimbursement.

- preparing annual service data reports which profile the health care services provided to the students in the district and the costs for each of those services.

A management company may eliminate or lessen a district's concerns for

- managerial staff time necessary to set up, operate and maintain the system.

- costs for providing or hiring additional staff to perform the day-to-day activities associated with accessing third-party plans.

- computer hardware and software necessary to handle the required paperwork.

- experience necessary to effectively access WMAP and private insurance companies.

- expertise related to follow-up on rejected claims from WMAP or private insurance companies.

- knowledge of how to develop a system to handle students who cycle in and out of public program eligibility.

There are advantages and incentives for a district to contract with a management company/third-party administrator. However, LEAs must take the normal precautions when contracting out such as timeframes for renewal or cancellation of contracts and/or liability issues. In addition, the LEA must investigate and take into account the special circumstances of the health care financing sector relating to fees for services rendered.

Some management companies may want to charge an up-front fee. Others might ask for a percentage of the third-party funds paid to the school district. Such contractual relationships for payment of services rendered may be appropriate for private insurance claims <u>but are not allowed for WMAP-based claims</u>. The WMAP prohibits a billing agent from charging for services rendered based on the amount of Medicaid dollars paid. Management fees, under contracts for billing claims to the WMAP, must be based on the costs of doing business rather than the revenues generated by such claims.

School districts have several options available to them as they decide how best to maximize payment of third-party monies. The decision process should take into account each LEA's unique circumstances and available resources. The LEA should keep foremost in mind its relationship with the student and the student's family and the fact that the LEA is ultimately accountable for the services they provide and the funds they collect from third-parties.

GLOSSARY

GLOSSARY

Adjuster - an individual, often referred to as a claims representative, who acts for an insurance company in the settlement of a medical claim.

Assignment - the transfer of the legal rights under a contract from one person to another.

Assignment-of-benefits - an agreement between the patient and provider which transfers the right to receive direct payment from an insurance plan for benefits payable by the plan.

Attending physician - the physician in charge of the patient's medical care.

Beneficiary - a person eligible to receive benefits under a medical or health care plan.

Benefit - an amount payable by an insurance plan to the insured or a designee for services or procedures covered by the insurance plan.

Birthday rule - the rule, associated with the process of coordination of benefits, in which the insurer of the party whose birthday falls first in a calendar year becomes the primary carrier.

Capitation - a method of payment for health care services in which the provider is paid a fixed fee for each person enrolled in an insurance plan. The monetary allowance for each enrollee is usually based on average costs adjusted for age, sex, and so forth, not on the type or number of services rendered to individual patients.

Carrier - the insurance company, also referred to as the insurer.

Claim - a written or electronically submitted demand for payment of benefits for covered services; standardized claim forms include the HCFA 1500 and UB82.

COBRA - (Consolidated Omnibus Reconciliation Act of 1985) - federal legislation which mandates to some persons who would otherwise lose group health insurance coverage the right to continue coverage under the group plan for a limited time period. Employees who terminate employment for any reason other than gross misconduct, those whose hours are reduced, and dependents of these employees may continue the group coverage for up to 18 months. Dependents may continue coverage for up to 36 months if they lose coverage for any of the following reasons: death of the employee, divorce from the employee, reaching the maximum age

allowed under the policy, or employee eligibility for Medicare. Premium costs for COBRA coverage are borne entirely by the insured and may total up to 102% of the total employer/employee premium contribution under the group plan.

Co-insurance - a provision of an insurance plan which stipulates the beneficiary's share of the cost of covered services, usually stated as a percentage of allowed charges.

Comprehensive insurance plan - a policy that provides both basic coverage and major medical protection. Benefits are usually paid at a set percentage of all covered charges after satisfaction of a periodic deductible.

Congenital anomaly - a medical condition, present at birth, which is significantly different from the norm.

Consent - voluntary agreement, based on an understanding of the nature of a particular action and the risks involved.

Contingent liability - a situation in which no present debt exists but conditions are such that a liability may develop.

Conversion rights - statutorily protected rights whereby all group health plans are required to permit a group member to obtain an individual policy if the group plan is terminated by the insurer or if the employee/member terminates the group. Conversion rights are provided with no medical eligibility tests or waiting periods. (Wisconsin's continuation/conversion law is found in s. 632.897, Wis. Stats.)

Coordination of benefits - a clause written into a policy or a statutory requirement that obligates a carrier to take into account benefits payable by another plan, if the patient has more than one policy covering the same medical care services. The benefits from the combined policies may pay up to but not exceed 100% of the claimed charges.

Co-payment - the insured or beneficiary's liability, usually stated as a specified amount per unit of service. Co-payment amounts do not vary along with the variable charges billed by different providers for the same service.

Covered services - those medical or health care services provided to a patient which are stipulated by an insurance plan as eligible for benefit payments.

CPT-4 - Current Procedural Terminology (Fourth edition) a publication developed by the American Medical Association. One of the recognized procedural coding systems.

Deductible - the specified amount of medical care charges for covered services, deemed the insured's responsibility, which must be incurred before policy benefits are paid by the plan.

Deductible carryover - a policy provision which stipulates that deductible credits applied in a previous policy year, usually the last three months, will be used to help satisfy the next policy year's deductible.

Dependents - those individuals, other than the insured, who are eligible for coverage under the plan; generally, the insured's spouse and children.

Diagnosis code - the statistical code number for a specific diagnosis, assigned by the World Health Organization and used to transmit relevant patient diagnoses data to third-party payers.

Disposable medical supplies - those items which have a very limited life expectancy and are consumable, expendable, disposable, or nondurable (per the Wisconsin Medical Assistance Program).

Durable medical equipment - equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and generally is not useful to a person in the absence of illness or injury (per the Wisconsin Medical Assistance Program).

Effective date - the date the insurance contract commences, not necessarily the same date coverage begins.

Electronic claims submission - claims prepared in a manner compatible with subsequent delivery to the third-party payer via magnetic media or telecommunications device.

ERISA (Employee Retirement Income Security Act) - Congressionally enacted pension reform legislation of 1974 that includes stipulations which have evolved to provide insulation, for self-funded plans, from individual state's insurance regulations.

EOB (Explanation of Benefits) - written statement from the third-party payer which attempts to explain details of benefit calculations and/or reasons(s) for rejection of certain charges.

Fee for service - liability or benefit payment of specified amounts for each service provided.

Fiduciary - an individual who has a duty created by undertaking to act for the benefit of another in a position of trust or of holding a confidence.

ICD-9 - International Classification of Diseases (Ninth revision) a publication by the World Health Organization.

ICD-9-CM - International Classification of Diseases: Clinical Modification (Ninth revision), a publication of the Commission on Professional and Hospital Activities in the United States.

Compatible with ICD-9 but arranged in a fashion which makes it possible to more easily encode, store, and retrieve diagnostic information from a patient's medical record. Published in three volumes: Volume 1 (numerical listing) and Volume 2 (alphabetical listing) are used by LEAs in the submission of claims to third-party payers.

Indemnity - benefit paid in money by an insurance policy for a covered loss.

Intermediary - an entity which processes claims submitted for coverage under government programs.

Medical record - data or information retained in some media form and related to the health status of and treatment rendered to a patient.

Participating provider - a medical care provider who has established a contractual relationship with a third-party payer to provide certain services to members of a plan.

Plan of care - a written statement which details a patient's medical condition, functional level, treatment plan, goals, and objectives along with the provider's orders, plan for ongoing care, and potential for discharge from treatment.

Precertification - the process of providing required notice of proposed treatment to the patient's third-party payer(s).

Pre-existing condition - an injury, disease, or physical condition afflicting an insured person prior to the effective date of an insurance policy. Such a condition need not have been treated but must have manifested itself in a manner which would have caused a prudent person to seek treatment for the condition. A policy may permanently preclude coverage for such conditions or stipulate that a certain lifetime benefit maximum will be paid for such conditions or provide full policy benefits after a period of time has elapsed.

Primary diagnosis - the condition considered to be the patient's major health problem for which treatment is rendered and on which the physician's claim is based.

Principal diagnosis - that diagnosis which has been found, after study of the peculiar situation, to necessitate treatment; only used in relation to claims billed by hospitals.

Principal procedure - the procedure which was performed for definitive treatment and which is most related to the principal diagnosis.

Prior authorization - third-party payer's consent to proceed with proposed treatment. Such consent is only in the context of the third-party's willingness to provide benefits for the treat-

ment if the insurance plan or government program eligibility remains in force at the time treatment is rendered.

Procedural code - a statistically based code number that can be used to transmit data to third-party payers about medical procedures performed on a patient.

Referring physician - the physician who sends his patient to another physician or allied health providers for consultation and/or treatment.

Reinsurance - a method used by an insurance company or a self-funded plan to transfer part of all of its liability for an insurance or benefit contract to another insurance company.

Rider - an amendment clause added to normal policy language; such amendments are often used by an insurance carrier to preclude coverage for certain conditions while maintaining all other policy benefits.

Subrogation rights - an insurance carrier's assumption of an obligation for which another carrier has primary liability while retaining the ability to collect from the primary carrier at a later date.

Subscribers - persons who contract with a third-party payer or participate in an employer's benefit plan to receive medical care coverage for themselves and eligible dependents.

Third-party payer - a public or private entity that insures against risk of loss or reimburses for expenses incurred in relation to the receipt of medical care services.

UCR (Usual Customary Reasonable) - a third party's method of benefit calculation which takes into account charges billed by all providers within a particular discipline and geographic region.

APPENDIX A

Information Update Bulletin #90.4

Exceptional Education
INFORMATION UPDATE

Wisconsin Department of Public Instruction / Herbert J. Grover, State Superintendent
125 South Webster Street / P.O. Box 7841 / Madison, Wisconsin 53707
Division for Handicapped Children & Pupil Services / Victor J. Contrucci, Administrator

BULLETIN NO. 90.4 April, 1990

TO: District Administrators, CESA Administrators, CHCEB Administrators, Directors of Special Education, Special Education Program Designees

FROM: Victor J. Contrucci, Assistant Superintendent VJC
Division for Handicapped Children and Pupil Services

SUBJECT: Third Party Payment for Certain Related Services

As districts are serving more students with severe health care needs and more students are receiving related services within the school setting, costs to districts continue to rise. There has been an increasing interest in the use of third party funds to help local districts pay the costs of services which are both educational and medical provided as part of special education. Where appropriate, the department encourages school districts to utilize third party funds to help pay for eligible services. The department has been exploring the ramifications and procedures for districts accessing these funds. Some districts in the state have begun collecting from third parties for some services they provide.

The Education of the Handicapped Act provides that the obligation of states and local educational agencies to provide a free appropriate public education does not relieve other agencies or insurers from otherwise valid obligations. In 1988, the Supreme Court ruled that Medicaid funds could be used for such services. Also in 1988, Congress passed the Medicare Catastrophic Coverage Act which contained a provision that state Medicaid programs could not refuse to pay for services solely because they were covered in a child's individualized education program (IEP) or individualized family service plan (IFSP). In Wisconsin, Medicaid is administered by the Department of Health and Social Services (DHSS) and is known as the Wisconsin Medical Assistance Program (WMAP).

SERVICES WHICH MIGHT BE COVERED

To be covered by WMAP or other third party payors, services must be medically necessary. In many cases, the services must be based on a physician's prescription. The services which most likely could be covered are occupational therapy, physical therapy, audiology services, and speech pathology. There are other services which some districts provide that might be covered by third parties. Medical necessity can result in some limitation to the coverage by third parties to less than the service provided by districts.

The Department of Public Instruction does not discriminate on the basis of race, sex, age, religion, handicap, or national origin.

ESTIMATING REVENUE FROM THIRD PARTY FUNDING

Various figures have been used by different sources to estimate the amount of revenue which claims to third parties would generate. Estimates of potential revenue range from $250-300 to about $1200 per child per year. The amount for any district would vary, depending on the number of children eligible for WMAP, the number of parents willing to assist in filing claims with private insurance, and the number of reimbursable services each child receives.

In determining the actual financial benefit to the district, consideration must be given to the costs of administration. Depending on a particular district's organization the administrative costs would vary. However, each individual therapist or clinician would need to keep additional records as would the district. Districts that claim third party reimbursement will need to make some changes in record keeping procedures as well, since confidentiality requirements for medical records are different from those for educational records.

Some districts have chosen to contract with private agencies to handle the claims with WMAP and private insurance. Such private services will process claims for a district in exchange for a percentage of the collections made. The district would still have record keeping obligations, but the private agency would handle billing records.

EFFECT ON CATEGORICAL AIDES

The department has determined that any receipts from third parties for special education and related services will not affect categorical aids received by districts. They would be deducted in the computation of shared cost in determining equalization aid eligibility.

POSSIBLE PROBLEM AREAS

It is essential for districts to gain voluntary parental consent for accessing insurance. It may be necessary to be able to demonstrate that requests for parental involvement do not appear coercive in case of any future litigation. The district providing services is liable for costs which are incurred by the student or parent. At this time, the greatest risk appears to be in the area of depletion of lifetime benefits, but there are means of limiting liability.

An agency may not pursue only WMAP for third party payments. WMAP is, by law, the payor of last resort, so it is necessary for a district to be able to show that it has at least attempted to pursue other sources of payment such as a family's group health insurance, as well as WMAP. It would appear to be discriminatory to seek outside payment for only low income or other WMAP eligible students, as opposed to all students covered by health insurance.

In dealing with third party payment of related or special education services, it is important to remember that a district is obligated to provide a free appropriate public education. To ensure that the educa-

tional program is free, there are assurances which a district must give to parents:
-A claim may not result in a decrease in available lifetime coverage or any other benefit under an insurance policy.
-A claim may not cause an increase in premiums or the discontinuation of the policy.
-The student or his/her family may not have an out-of-pocket expense such as a co-payment or a deductible.

Both private and WMAP health coverage is through a health maintenance organization (HMO) in some parts of the state. In general, providers of services must be a part of the HMO. However, WMAP will pay separately for services provided by schools for children who are otherwise covered by an HMO.

Private insurance creates some potential problems not encountered in dealing with WMAP. Some insurance contracts contain clauses which exclude services which are required to be provided by governmental agencies. Another clause which is found is that only the policy holder may be paid by the insurer, except in cases of assignment for which schools may not be eligible.

OVERVIEW OF PROCEDURES FOR CLAIMS

In order for a district to file claims with WMAP, the individual providing service (therapists or others) must be certified by WMAP and obtain an individual provider number. As a billing convenience, a district may obtain group billing numbers which would allow the district to receive payments for covered services provided by its individually certified staff.

Certification and billing numbers are obtained through the WMAP fiscal agent, E.D.S. Federal Corporation.

In submitting claims, it is necessary to complete a claim form for each individual receiving a service. The claim form includes basic demographic information, WMAP or insurance identification number as well as diagnostic and service codes and information. For each claim to WMAP, information about other insurance coverage is required, since WMAP is required by the Health Care Financing Administration to collect from any private insurance before WMAP pays a claim. Claims are filed with the insurance company or WMAP's fiscal agent.

ADDITIONAL INFORMATION

The department is working with DHSS to develop more detailed information for use by districts. By September, another bulletin will be issued with more detailed information about third party payments. Informational workshops will also be scheduled during the first half of the 1990-91 school year to assist districts in making decisions about pursuing third party payments and the procedures involved.

gsd

APPENDIX B

U.S. Department of Education,
Notice of Interpretation

DEPARTMENT OF EDUCATION

Office of Special Education

Office for Civil Rights

34 CFR Part 104 and 300

Nondiscrimination on the Basis of Handicap in Programs and Activities Receiving or Benefiting From Federal Financial Assistance; and Assistance to States for Education of Handicapped Children

AGENCY: Department of Education.

ACTION: Notice of Interpretation.

SUMMARY: The Secretary of Education interprets Part B of the Education of the Handicapped Act, as amended, and Section 504 of the Rehabilitation Act of 1973, as amended, concerning the use of parents' insurance proceeds to pay for required services. It is the Secretary's interpretation that these statutes and their implementing regulations do not permit an educational agency responsible for the education of a handicapped child to require the parents of that child to use private insurance proceeds to pay for required services where the parents would incur financial loss. This interpretation is issued in response to public inquiries regarding Departmental policy on the matter.

EFFECTIVE DATE: This interpretation is expected to take effect 45 days after it is transmitted to Congress. Interpretations are usually transmitted to Congress several days before they are published in the Federal Register. The effective date of interpretations that are subject to the transmittal requirement is changed if Congress takes certain adjournments. Although the interpretation of Section 504 is not subject to this requirement, the Secretary has decided to set its effective date for the same day that the interpretation of Part B of the Education of the Handicapped Act becomes effective. If you want to know the effective date of this interpretation, call or write the Department of Education contact persons.

FOR FURTHER INFORMATION CONTACT: Ms. Shirley A. Jones, Office of Special Education, Department of Education, Donohoe Building, Room 4030, 400 Maryland Ave. S.W., Washington, D.C. 20202, telephone: (202) 472-7921. Mr. Edward A. Stutman, Office for Civil Rights, Department of Education, Switzer Building, Room 5430, 300 C St., S.W., Washington, D.C. 20202, telephone: (202) 245-0781.

SUPPLEMENTARY INFORMATION:

The Issue

The issue is whether Part B of the Education of the Handicapped Act, as amended, ("Part B"; 20 U.S.C. 1411–1420) and its regulations (34 CFR Part 300; formerly 45 CFR Part 121a) and Section 504 of the Rehabilitation Act of 1973, as amended ("Section 504"; 29 U.S.C. 794) and its regulations (34 CFR Part 104; formerly 45 CFR Part 84) permit an educational agency responsible for the education of a handicapped child to require the child's parents to file insurance claims and use the proceeds to pay for services that must be provided to the child under Part B and Section 504.

The Interpretation

Both Part B and Section 504 prohibit a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a handicapped child under the "free appropriate public education" requirements of those statutes. The use of parents' insurance proceeds to pay for services in these circumstances must be voluntary on the part of the parents.

Discussion

Under Section 612(2)(B) of Part B (20 U.S.C. 1412(2)(B)), each participating State must make available to all handicapped children within specified ages a free appropriate public education. "Free appropriate public education" is defined in Section 602(18) of the Education of the Handicapped Act, as amended, (20 U.S.C. 1401(18)) as "special education and related services which are provided at public expense, under public supervision and direction, and without charge. . . ." The requirement to provide these services is implemented in 34 CFR 300.300 *et seq.*

Similarly, the Department's regulations implementing Section 504 require any recipient of Federal financial assistance that operates a public elementary or secondary education program to "provide a free appropriate public education to each qualified handicapped person who is in the recipient's jurisdiction, regardless of the nature or severity of the person's handicap." 34 CFR 104.33(a). The provision of a free education is defined as "the provision of educational and related services without cost to the handicapped person or to his or her parents or guardian, except for those fees that are imposed on non-handicapped persons or their parents or guardian." 34 CFR 104.33(c).

The Secretary interprets the requirements that a free appropriate public education be provided "without charge" or "without cost" to mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of handicapped children would suffer a finanial loss not incurred by similarly situated parents of non-handicapped children. Financial losses include, but are not limited to, the following:

(1) A decrease in available lifetime coverage or any other benefit under an insurance policy;

(2) An increase in premiums or the discontinuation of the policy; or

(3) An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

Financial losses do not include incidental costs such as the time needed to file an insurance claim or the postage needed to mail the claim.

The statutory and regulatory provisions relating to a free appropriate public education guarantee freedom only from financial loss as described above. Therefore, when the educational agency pays the financial costs related to filing a claim and no other cost (such as those listed above) is imposed, the parent suffers no financial loss. In addition, an agency may insist that parents file a claim when they would incur only minor incidental costs such as the time required to complete the form. The agency may require the parents to file a claim if it ensures that parents do not have to bear even a short-term financial loss. For example, if benefits begin only after a $50.00 deductible, the agency may insist that the parents file a claim if it pays for the services and the deductible in advance.

(20 U.S.C. 1401, 1411–1420; 29 U.S.C. 794)

The responsibility to make available a free appropriate public education does not mean that a public educational agency must use only its own funds for that purpose. An agency may use whatever State, local, Federal, and private sources of support are available to pay for required services. See 34 CFR 300.301(a) and 34 CFR 104.33(c)(1). Moreover, nothing in the Part B or Section 504 regulations relieves an insuror or similar third party from an otherwise valid obligation to provide or pay for services to a handicapped child. See 34 CFR 300.301(b) and 34 CFR 104.33(c).

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APPENDIX C

Provider Qualification

WMAP Provider Qualifications

1. Audiologist

HSS 105.31 Certification of audiologists. For MA certification, audiologists shall:

(1) Possess a certificate of clinical competence from the American speech and hearing association (ASHA);

(2) Have completed the educational requirements and work experience necessary for the certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate under sub.(1).

NOTE:

As of December 1, 1990 and ending on June 30, 1993, audiologists will be required to be registered under the Wisconsin Department of Regulation and Licensing. Then on July 1, 1993, audiologists will be licensed by the Wisconsin Department of Regulation and Licensing pursuant to subch. II of ch. 459, WIS STATS. This registration and subsequent licensure will probably become the standard for qualification of audiologists as providers.

2. Nurses

Independent Nurses

HSS 105.19 CERTIFICATION OF INDEPENDENT NURSES. (1) For MA certification, an independent registered nurse shall be licensed pursuant to s. 441.06, Stats.

(2) For MA certification, an independent licensed practical nurse shall be licensed pursuant to s. 441.10, Stats.

Nurse Practitioners

HSS 105.20 CERTIFICATION OF NURSE PRACTITIONERS. (1) QUALIFICATIONS. For MA certification, a nurse practitioner shall be licensed as a registered nurse pursuant to s. 441.06, Stats., and fulfill one of the following requirements:

(a) If practicing as a pediatric nurse practitioner, be currently certified by the American nurses' association or by the national board of pediatric nurse practitioners and associates;

(b) If practicing as any family nurse practitioner, be currently certified by the American nurses' association; or

(c) If practicing as any other primary care nurse practitioner or as a clinical nurse specialist, be currently certified by the American nurses association, the national certification board of pediatric nurse practitioners and associates, or the nurses' association of the American college of obstetricians and gynecologists' certification corporation, or have a master's degree in nursing from a school accredited by a program designed to prepare a registered nurse for advanced clinical nurse practice.

(2) PROTOCOLS. A written protocol covering a service or delegated medical act that may be provided and procedures that are to be followed for provision of services by nurse practitioners shall be developed and maintained by the nurse practitioner and the delegating licensed physician according to the requirements of s. N 6.03(2) and the guidelines set forth by the board of nursing. This protocol shall include, but is not limited to, explicit agreements regarding those delegated medical acts which the nurse practitioner or clinical nurse specialist is delegated by the physician to provide. A protocol shall also include arrangements for communication of the physician's directions, consultation with the physician, assistance with medical emergencies, patient referrals and other provisions relating to medical procedures and treatment.

NOTE:

The preceding MA certification requirements for nurses became effective September 6, 1990.

3. **Occupational Therapist (OT)**

HSS 105.28 Certification of occupational therapists and assistants. (1) OCCUPATIONAL THERAPISTS. For MA certification, an occupational therapist shall:

(a) Be certified by the American occupational therapy association as an occupational therapist, registered; or

(b) Have graduated from a program in occupational therapy accredited by the council on medical education of the American medical association and the American occupational therapy association, have completed the required field work experience, and have made application to the American occupational therapy association for the certification examination for occupational therapist, registered. Certification under this paragraph shall be valid until 8 weeks after the examination is taken. On passing the examination, the therapist shall obtain certification by the American occupational therapy association in the calendar year in which the examination is taken. An individual certified under this paragraph for medical assistance who fails the examination may be recerti-

fied for medical assistance only under the conditions of par. (a).

NOTE:

As of November 1, 1989 occupational therapists came under the regulation of the Wisconsin Department of Regulation and Licensing, and the Occupational Therapy Examining Board. By November 1, 1991 occupational therapists shall be certified pursuant to ss. 448.05 WIS STATS and ch. Med. 19 of the Wisconsin Administrative Code for the Medical Examining Board. This certification will probably be the new standard for qualification of the occupational therapists as providers.

Occupational Therapy Assistant (OTA)

HSS 105.28 (2) OCCUPATIONAL THERAPY ASSISTANTS. For MA certification, occupational therapy assistants shall be certified by the American occupational therapy association. Occupational therapy assistants may not bill or be reimbursed directly for their services. Occupational therapy assistants shall provide services under the direct, immediate on-premises supervision of an occupational therapist certified under sub. (1), except that they may provide services under the general supervision of an occupational therapist certified under sub. (1) under the following circumstances:

(a) The occupational therapy assistant is performing services which are for the purpose of providing activities of daily living skills;

(b) The occupational therapy assistant's supervisor visits the recipient on a bi-weekly basis or after every 5 visits by the occupational therapy assistant to the recipient, whichever is greater; and

(c) The occupational therapy assistant and his or her supervisor meet to discuss treatment of the recipient after every 5 contacts between the occupational therapy assistant and the recipient.

NOTE:

As of November 1, 1989 occupational therapy assistants came under the regulation of the Wisconsin Department of Regulation and Licensing and the Occupational Therapy Examining Board. By November 1, 1991 occupational therapy assistants shall be certified pursuant to ss. 448.05 WIS STATS and ch. Med. 19 of the Wisconsin Administrative Code for the Medical Examining Board. This certification will probably be the new standard for qualification of the OTAs as providers.

Please note that currently a school district can hire a occupational therapy assistant (OTA) as a special education therapy

aide. Per Division for Handicapped Children and Pupil Services, Information Bulletin Update #89.10, the responsibilities of a special education therapy aide are:

a. To escort children to and from the designated therapy service area.

b. To prepare a child for therapy.

c. To assist in dressing.

d. To assist in removal and replacement of prosthesis.

e. To prepare equipment and materials.

If a person is hired as an aide, then the person must function as an aide. For a OTA to provide direct occupational therapy in the schools at this time goes beyond current DPI policy of a special education therapy aide.

4. **Physical Therapist (PT)**

HSS 105.27 Certification of physical therapists and assistants. (1) PHYSICAL THERAPISTS. For MA certification, physical therapists shall be licensed pursuant to ss. 448.05 and 448.07, Stats., and ch. Med 7.

Physical Therapist Assistant (PTA)

(2) PHYSICAL THERAPIST ASSISTANTS. For MA certification, physical therapist assistants shall have graduated from a 2-year college-level program approved by the American physical therapy association, and shall provide their services under the direct, immediate, on-premises supervision of a physical therapist certified pursuant to sub. (1). Physical therapist assistants may not bill or be reimbursed directly for their services.

NOTE:

Currently, school districts can hire a PTA as a special education therapy aide. Per Division for Handicapped Children and Pupil Services, Information Bulletin Update #89.10, the responsibilities of a special education therapy aide are:

a. To escort children to and from the designated therapy service area.

b. To prepare a child for therapy.

c. To assist in dressing.

d. To assist in removal and replacement of prosthesis.

e. To prepare equipment and materials.

If a person is hired as an aide, then the person must function as an aide. For a PTA to provide direct physical therapy in the schools at this time goes beyond current DPI policy of a special education therapy aide.

5. **Psychologist and Social Worker**

HSS 105.22 Certification of psychotherapy providers. (1) TYPES OF PSYCHOTHERAPY PROVIDERS. For MA certification, psychotherapy providers shall be one of the following:

(a) A physician meeting the requirements of s. HSS 105.05(1) who has completed a residency in psychiatry. Proof of residency shall be provided to the department. Proof of residency shall either be board-certification from the American board of psychiatry and neurology or a letter from the hospital in which the residency was completed;

(b) A psychologist licensed under ch. 455, Stats., who is listed or eligible to be listed in the national register of health services providers in psychology;

(c) A board-operated outpatient facility certified under ss. HSS 61.91 to 61.98; or

(d) An outpatient facility certified under ss. HSS 61.91 to 61.98, which provides MA services under contract to a board.

(3)(b) A person eligible under this subsection to provide psychotherapy services as an employe of a board-operated or hospital outpatient psychotherapy facility shall be one of the following:

1. A person with a master's degree in social work from a graduate school of social work accredited by the council on social work education, with course work emphasis in case work or clinical social work and who is listed in or eligible to be listed in either the national association of social workers (NASW) register of clinical social workers or the national registry of health care providers in clinical social work;

2. A person with a master's degree in psychiatric mental health nursing from a graduate school of nursing accredited by the national league for nursing;

3. A person with any of the following master's degrees and course work emphasis in clinical psychology: counseling and guidance, counseling psychology, clinical psychology, psychology or school psychology, if the person has met the equivalent of the requirements for registration in the national registry of health care providers in clinical

social work or in the NASW register of clinical social workers; or

4. A physician meeting the requirements of sub. (1) (a) or a psychologist meeting the requirements of sub. (1) (b).

(c) Providers defined by par. (b) 1 to 3 shall also have 3,000 hours of supervised experience in clinical practice subsequent to the acquisition of an acceptable masters degree. In this paragraph, "supervised" during the 3,000 hour period means a minimum of one hour a week of face-to-face supervision by another person meeting the minimum qualifications to be a provider.

(4) REIMBURSEMENT FOR OUTPATIENT PSYCHOTHERAPY SERVICES. Outpatient psychotherapy services shall be reimbursed as follows:

(a) For the services of any provider working in a certified outpatient facility, reimbursement shall be to the facility; and

(b) For the services of any provider in private practice who is licensed and certified according to sub. (1) (a) or (b), reimbursement shall be to that provider.

6. **Speech Pathologist**

HSS 105.30 Certification of speech pathologists. For MA certification, speech pathologists shall:

(1) Possess a current certification of clinical competence from the American speech and hearing association;

(2) Have completed the educational requirements and work experience necessary for such a certificate; or

(3) Have completed the educational requirements and be in the process of accumulating the work experience required to qualify for the certificate of clinical competence under sub. (1).

The Wisconsin Medical Assistance Provider Handbook indicates that:

Equivalent educational requirements consist of a master's degree. Equivalent work experience consists of one year of supervised training by a program certifiable speech/language pathologist. Speech/language pathologists having a bachelor's degree with a major emphasis in speech/language pathology from an accredited college or university are eligible to participate in the program if supervised by a speech/language pathologist certified pursuant to section HSS 105.30, Wisconsin Administrative Code.

NOTE:

As of December 1, 1990 and ending on June 30, 1993 speech-language pathologists (except speech-language pathologists employed in positions for which a speech and language pathology license issued by the Department of Public Instruction is required) will be required to be registered under the Wisconsin Department of Regulation and Licensing. Then on July 1, 1993, speech-language pathologists (except speech-language pathologists employed in positions for which a speech and language pathology license issued by the Department of Public Instruction is required) will be licensed by the Wisconsin Department of Regulation and Licensing pursuant to subch. II of ch. 459, WIS. STATS. This registration and subsequent licensure could become the standard for qualification of speech-language pathologists as providers, regardless of employment setting.

Physical Therapist

a. Physical therapy.

(1) "Physical therapy" means services prescribed by a physician and provided to a recipient or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A "qualified physical therapist" is an individual who is--

(i) A graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent; and

(ii) Where applicable, licensed by the State.

Occupational Therapist

b. Occupational therapy.

(1) "Occupational therapy" means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A "qualified occupational therapist" is an individual who is--

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

Speech-Language Pathologist & Audiologist

c. Services for individuals with speech, hearing, and language disorders.

(1) "services for individuals with speech, hearing, and language disorders" means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. It includes any necessary supplies and equipment.

(2) A "speech pathologist or audiologist" is an individual who--

(i) Has a certificate of clinical competence from the American Speech and Hearing Association;

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

APPENDIX D

AFDC-Related Assets & Income Table

SSI-Related Assets & Income Table

Healthy Start Income Table

WMAP Eligible Recipients

Health Insurance Risk Sharing Plan

AFDC-RELATED ASSETS & INCOME TABLE

Group Size	Categorically Needy			Medically Needy	
	Assets	Income		Assets	Income
		Area I	Area II		
1	$1,000	$ 311	$ 301	$2,000	$ 488.72
2	1,000	550	533	3,000	591.67
3	1,000	647	626	3,300	689.33
4	1,000	772	749	3,600	822.67
5	1,000	886	861	3,900	944.00
6	1,000	958	929	4,200	1,021.33
7	1,000	1,037	1,007	4,500	1,105.33
8	1,000	1,099	1,068	4,800	1,172.00
9	1,000	1,151	1,117	5,100	1,226.67
10	1,000	1,179	1,143	5,400	1,257.33
11	1,000	1,204	1,168	5,700	1,284.00
12	1,000	1,229	1,193	6,000	1,310.67
13	1,000	1,254	1,218	6,300	1,337.33
14	1,000	1,279	1,243	6,600	1,364.00
15	1,000	1,304	1,268	6,900	1,390.67
16	1,000	1,329	1,293	7,200	1,417.33
17	1,000	1,354	1,318	7,500	1,444.00
18	1,000	1,379	1,343	7,800	1,470.67
+	1,000	+25 each	+25 each	+300 each	+26.67 each person above 18

SOURCE: WMAP Eligibility Handbook (7/1/90)

SSI-RELATED ASSETS & INCOME TABLE

Group Size	Categorically Needy Limits		Medically Needy Limits	
	Assets	Income	Assets	Income
1	$2,000	$360.05 (+ actual shelter up to $128.67)	$2,000	$488.72
2	$3,000	$551.86 (+ actual shelter up to $193.00)	$3,000	$591.67

SOURCE: WMAP Elgibility Handbook (7/1/90)

HEALTHY START INCOME TABLE

Fiscal Group Size	Categorically Needy	Fiscal Group Size	Medically Needy
1	$ 696.03	1	$ 811.17
2	933.22	2	1,087.58
3	1,170.40	3	1,364.00
4	1,407.58	4	1,640.42
5	1,644.77	5	1,916.83
6	1,881.95	6	2,193.25
7	2,119.13	7	2,469.67
8	2,356.32	8	2,746.08
Add $237.18 for each additional person.		Add $276.42 for each additional person.	

SOURCE: WMAP Eligibility Handbook (7/1/90)

WMAP ELIGIBLE RECIPIENTS

County Name	Number of Children Under Age 21	County Name	Number of Children Under Age 21
Adams	467	Milwaukee	68,667
Ashland	474	Monroe	726
Barron	902	Oconto	451
Bayfield	246	Oneida	634
Brown	3,888	Outagamie	1,649
Buffalo	203	Ozaukee	159
Burnett	405	Pepin	126
Calumet	254	Pierce	289
Chippewa	1,240	Polk	880
Clark	463	Portage	1,181
Columbia	493	Price	246
Crawford	271	Racine	6,488
Dane	4,717	Richland	319
Dodge	766	Rock	4,548
Door	325	Rusk	419
Douglas	1,621	St. Croix	432
Dunn	781	Sauk	666
Eau Claire	2,638	Sawyer	681
Florence	102	Shawano	589
Fond du Lac	1,234	Sheboygan	1,624
Forest	357	Taylor	198
Grant	641	Trempealeau	382
Green	336	Vernon	452
Green Lake	243	Vilas	223
Iowa	203	Walworth	597
Iron	86	Washburn	298
Jackson	472	Washington	596
Jefferson	667	Waukesha	1,537
Juneau	443	Waupaca	596
Kenosha	4,283	Waushara	354
Kewaunee	186	Winnebago	2,306
La Crosse	2,901	Wood	1,351
Lafayette	214	Menominee	806
Langlade	424	Redcliff	130
Lincoln	434	Stockbridge	96
Manitowoc	1,314	Lac Du Flambeau	280
Marathon	2,129	Bad River	180
Marinette	791	Oneida	493
Marquette	215		
		STATE TOTAL	139,478

SOURCE: DHSS, August 31, 1990

Premium Zone 1:
Includes ZIP codes with the first three numbers 532.

Premium Zone 2:
Includes ZIP codes with the first three numbers 530, 531, 534 or 537.

Premium Zone 3:
Includes ZIP codes other than those noted for zones 1, 2 and 4.

Premium Zone 4:
Includes ZIP codes with the first three numbers 540 or 547.

PREMIUM RATE TABLES

Zone 1 — Major Medical Plan

Age Group	Annual		Quarterly	
	Male	Female	Male	Female
0-18	$ 720.00	$ 720.00	$180.00	$180.00
19-24	720.00	1,212.00	180.00	303.00
25-29	720.00	1,212.00	180.00	303.00
30-34	848.00	1,368.00	212.00	342.00
35-39	848.00	1,368.00	212.00	342.00
40-44	1,092.00	1,552.00	273.00	388.00
45-49	1,332.00	1,668.00	333.00	417.00
50-54	1,640.00	1,796.00	410.00	449.00
55-59	2,064.00	1,924.00	516.00	481.00
60-64	2,480.00	2,104.00	620.00	526.00

Zone 2 — Major Medical Plan

Age Group	Annual		Quarterly	
	Male	Female	Male	Female
0-18	$ 676.00	$ 676.00	$169.00	$169.00
19-24	676.00	1,092.00	169.00	273.00
25-29	676.00	1,092.00	169.00	273.00
30-34	820.00	1,232.00	205.00	308.00
35-39	820.00	1,232.00	205.00	308.00
40-44	996.00	1,396.00	249.00	349.00
45-49	1,216.00	1,500.00	304.00	375.00
50-54	1,476.00	1,616.00	369.00	404.00
55-59	1,856.00	1,732.00	464.00	433.00
60-64	2,232.00	1,904.00	558.00	476.00

Zone 3 — Major Medical Plan

Age Group	Annual		Quarterly	
	Male	Female	Male	Female
0-18	$ 576.00	$ 576.00	$144.00	$144.00
19-24	576.00	968.00	144.00	242.00
25-29	576.00	968.00	144.00	242.00
30-34	700.00	1,096.00	175.00	274.00
35-39	700.00	1,096.00	175.00	274.00
40-44	872.00	1,240.00	218.00	310.00
45-49	1,064.00	1,336.00	266.00	334.00
50-54	1,312.00	1,436.00	328.00	359.00
55-59	1,652.00	1,540.00	413.00	385.00
60-64	1,984.00	1,684.00	496.00	421.00

Zone 4 — Major Medical Plan

Age Group	Annual		Quarterly	
	Male	Female	Male	Female
0-18	$ 676.00	$ 676.00	$169.00	$169.00
19-24	676.00	1,040.00	169.00	260.00
25-29	676.00	1,040.00	169.00	260.00
30-34	820.00	1,192.00	205.00	298.00
35-39	820.00	1,192.00	205.00	298.00
40-44	996.00	1,320.00	249.00	330.00
45-49	1,216.00	1,420.00	304.00	355.00
50-54	1,468.00	1,540.00	367.00	385.00
55-59	1,784.00	1,660.00	446.00	415.00
60-64	2,140.00	1,904.00	535.00	476.00

Disability Medicare Plan

	Zones 1 and 2		Zone 3		Zone 4	
	Annual	Quarterly	Annual	Quarterly	Annual	Quarterly
All Policyholders	$1,136.00	$284.00	$1,024.00	$256.00	$1,136.00	$284.00

Semiannual premiums equal one-half of the annual premium

NOTE: The Medicare Part A deductible for 1990 is $592.00

APPENDIX E

BCPN Referral Form

WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION
REFERRAL TO BCPN
PI-2192 (Rev. 1-83)

INSTRUCTIONS: Complete and return to:
WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION
DIVISION FOR HANDICAPPED CHILDREN AND PUPIL SERVICES
BUREAU FOR CHILDREN WITH PHYSICAL NEEDS
125 SOUTH WEBSTER STREET
P.O. BOX 7841
MADISON, WI 53707

GENERAL INFORMATION

Child's Complete Name	Birthdate *Mo./Day/Yr.*	Today's Date
Address *Street, City, County, ZIP*		Telephone *Area/No.*

Sex *Check*: ☐M ☐F

Ethnic Category* *Check*: ☐ Amer. Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Hispanic ☐ Black ☐ White *Not of Hispanic origin*

Parent/Guardian

REFERRAL INFORMATION

Description of Child's Problem(s):

Services Requested of BCPN:

Physician(s) Name(s) and Address(es): *Include family pediatrician and specialists*

Name(s) and Address(es) of Other Professionals/Agencies Involved with Child:

Educational Placement (Name of School)

Is the child enrolled in special education classes?
☐ Yes ☐ No

Has application been made on child's behalf for supplemental security income?
☐ Yes, *Date of application* _____
☐ No

Has child been certified for Title 19 (medical assistance) in the last six months?
☐ Yes, *Provide date and certification number* _____
☐ No

Is family aware of this referral?
☐ Yes
☐ No

Name, Address, Telephone Number of Referring Person/Agency

For BCPN Use Only

BCPN Disposition of Referral *Include date(s)*

*See reverse for definitions

Ethnic Category Definitions:

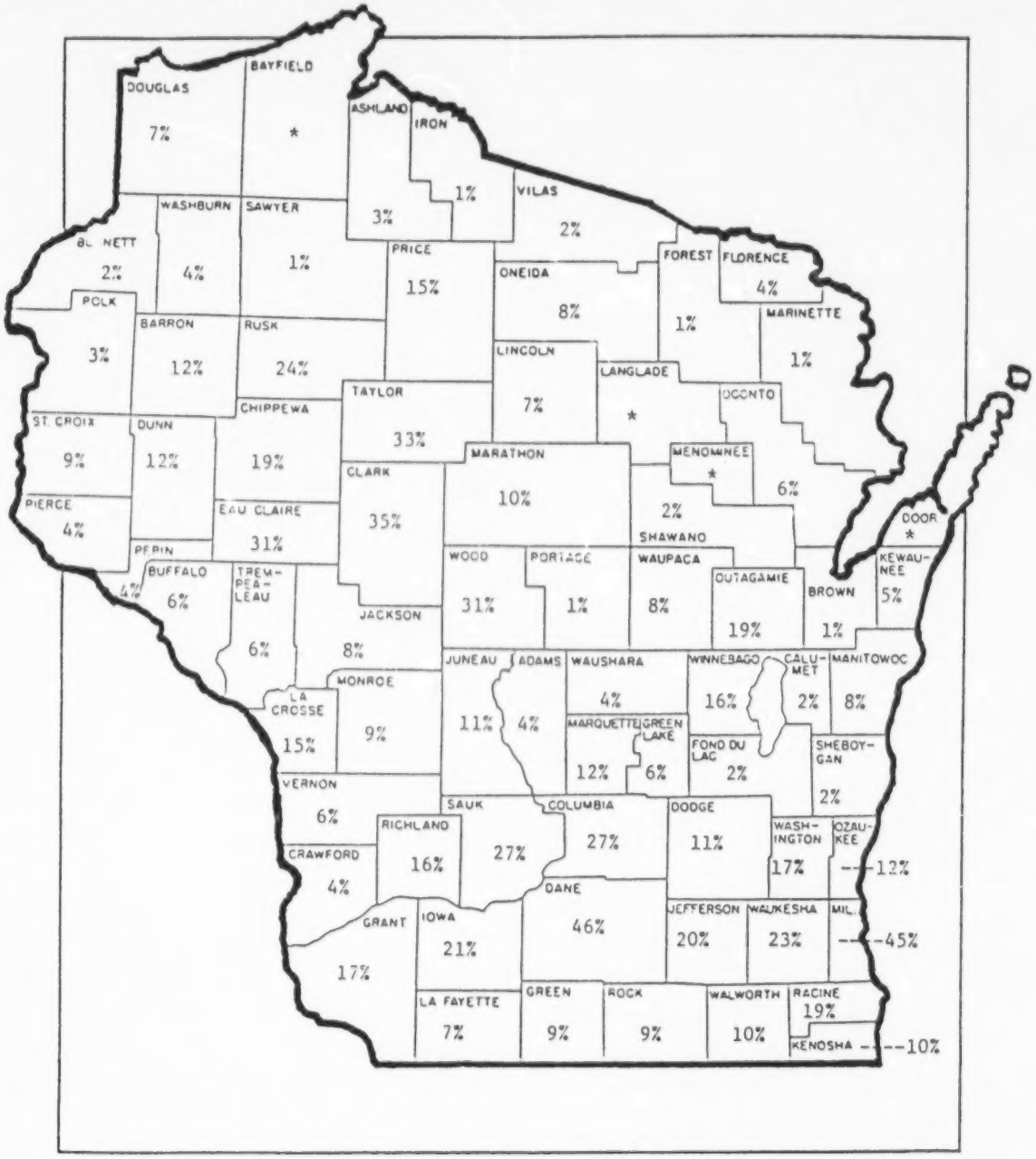
1. **American Indian or Alaskan Native**—A person having origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.
2. **Asian or Pacific Islander**—A person having origins in any of the original peoples of the Far East, Southeast Asia, the Pacific Islands, or the Indian subcontinent. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.
3. **Black, not of Hispanic Origin**—A person having origins in any of the black racial groups of Africa.
4. **Hispanic**—A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish Culture or origin, regardless of race.
5. **White, not of Hispanic Origin**—A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

APPENDIX F

HMO Enrollment by County

HMOs Licensed in Wisconsin

HMO ENROLLMENT BY COUNTY - JANUARY 1, 1990 *Wisconsin Counties*



- Percentages are based upon 1988 estimated population figures and are rounded to the nearest whole number

* = less than 1% of population enrolled in HMOs

Source: Office of Commissioner of Insurance

HEALTH MAINTENANCE ORGANIZATIONS LICENSED IN WISCONSIN

Aetna Healthcare Assurance Programs of Wisconsin, Inc.
AllHealth
Community Choice Health Plan, Inc.
Compcare Health Services Insurance Corporation
Dean Health Plan, Inc.
Employers Health Insurance Company Plan
Family Health Plan Cooperative
Greater LaCrosse Health Plans, Inc.
Group Health Cooperative of Eau Claire
Group Health Cooperative of South Central Wisconsin
Health Protection Plans
- Eau Claire-Chippewa Health Protection Plan
- Green Bay Health Protection Plan
- Oshkosh Area Health Protection Plan
- Wisconsin Rapids Health Protection

Heritage National Healthplan, Inc.
HMO Illinois, Inc.
HMO Midwest
HMO of Wisconsin Insurance Cooperation
Maxicare Health Insurance Company
MedCenters Health Care, Inc.
Medical Associates Clinic Health Plan of Wisconsin, The
MetLife Healthcare Network of WI, Inc.
Midelfort Health Plan, Inc.
Network Health Plan of Wisconsin, Inc.
North Central Health Protection Plan
Physicians Plus Insurance Corporation
PrimeCare Health Plan, Inc.
Q Care
Samaritan Health Insurance Corporation
Security Health Plan of Wisconsin, Inc.
U-Care HMO, Inc.
United Health Plan of Wisconsin Insurance Company, Inc.
Wisconsin Health Organization Insurance Corporation

Source: Office of Commissioner of Insurance, June 1990

APPENDIX G

Illustrations of Correspondence

INTRODUCTORY LETTER TO FAMILY

Re: Child's Name

Dear Mr. and Mrs.

Your child (Ralph) is enrolled in our special education program and is entitled to those related services necessary to ensure (him) an appropriate educational experience. Our school district is required to provide these services at no cost to your family. However, with your consent, we can seek funds from other than government sources, to help cover the costs of these related services.

Related services include activities such as physical and occupational therapy and speech pathology. These services could be considered medical expenses if they were provided by a private agency or at a medical facility. It is the nature of the service which has led the federal government, U.S. Congress, and Wisconsin's legislature to encourage local school districts to submit claims to medical/health insurance plans. However, our contact with your insurance plan(s) is subject to your approval.

Funds obtained from insurance plans will be used to help offset the costs of providing these services.

Our school district needs your voluntary consent to contact your insurance plan(s), whether they be private insurance or public programs such as the Wisconsin Medical Assistance Program. I ask that you review the enclosed informational letter and keep it with your records. Would you then please complete the consent and information request documents, sign and date them, and return them to our office in the enclosed envelope.

Your contact person here at the school district office relating to this matter will be _____. If you have any questions, write or call at (608) 292-1114.

Thank you for your cooperation.

Sincerely,

Special Education Director

FACT SHEET AND STATEMENT OF ASSURANCE

Dear Mr. and Mrs.

(Insert school district-specific summaries of special education and related services, including student demographics and financial facts.)

Policy Statement on Reimbursement of Depleted Insurance Plan Benefits

It is the policy of the School District of _____ to absorb any deductible or co-insurance amounts applied by an insurance plan to a claim for school-based medical services. In the event that school-based claims exhaust benefits that would otherwise have been paid on claims filed for medical care rendered outside the school, then the School District of _____ will reimburse the insurance plan policyholder an amount equal to the benefits that would have been paid if there had not been school-based claims. The maximum reimbursement by the school district will be the total amount paid to the school district by the insurance plan. The school district will make every effort to promptly settle with the policyholder; however, the policyholder should contact the school district within one year of the date the expenses in question were incurred.

Sincerely,

Special Education Director

P.S. Please contact _____ at (___) _____, if you should have any questions regarding our school district's contact with your insurance plan.

PARENT CONSENT TO ACCESS MEDICAL/HEALTH INSURANCE

Before the _____ School District can contact your medical/health insurance plan(s) for the purpose of filing claims for services provided as part of special education to your child, we need to obtain your voluntary written consent. If you grant consent, your consent will be in effect for one year or until you notify us in writing of your intent to revoke your consent. Your consent or non-consent will not alter the quality, type, or duration of services for your child as specified in his/her individualized education program.

Please read the enclosed statement of parent and child rights. This statement includes other rights you have as the parent of a child who receives special education and related services.

Please indicate your decision below and return this form in the enclosed envelope.

_____

_____

I/we hereby give consent to the _____ School District to file claims with my/our medical/health insurance plan(s) for the cost of services provided as part of special education to my/our child, _____. I/we have received, read, and understand my/our rights.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Parent/Legal Guardian Date

---------- OR ----------

I/we do not give consent to the _____ School District to file claims with my/our medical/health insurance plan(s) for the cost of services provided as part of special education to my/our child, _____. I/we have received, read, and understand my/our rights.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Parent/Legal Guardian Date

If you gave consent to allow the district to file claims with your insurance plan(s), please complete the other side of this page.

ASSIGNMENT OF BENEFITS

I/we hereby assign to the School District of _____ and/or its agent(s)/contractee(s) any proceeds (including major medical benefits) available under any group/individual insurance contract, service plan, or employee benefit plan which covers my/our dependent. This assignment pertains to medical-related services provided my/our dependent under the auspices of the School District of _____. This assignment will lapse one calendar year from the date affixed below with my/our signature(s).

INFORMED CONSENT FOR RELEASE OF INFORMATION

I/we do hereby authorize _____ School District and/or their agent(s) to release to applicable private and public insurance plans any medical information (including but not limited to diagnosis and treatment records) related to special education and related services provided the student named below. I/we understand such medical information will be used to determine, from the insurance plan's perspective, benefits payable under the plan or appropriateness of treatment services. I/we understand this consent in no way implies any financial liability on my/our part for any of these special education and related services. I/we understand this consent is voluntary and will lapse one year from the date affixed with my/our signature(s).

Student Name	Student's Date of Birth
Parent/Legal Guardian	Parent/Legal Guardian
Signature Date	Signature Date
Relationship to Student	Relationship to Student

112

_____
Student Name

Dear Mr. and Mrs. _____:

Please review and complete both sides of this information request form.

The following information is needed to properly file claims to your insurance plan(s). If you can, send us a photocopy (both sides) of your insurance ID card(s).

If both parents have an insurance policy covering the student, then the parent whose birthday comes first in the calendar year is the insured with the primary plan. In those cases in which the student is a child of separated or divorced parents, then the parent with custody of the student has the primary plan, unless otherwise stipulated by court decree.

PRIMARY INSURANCE PLAN

INSURED'S NAME _____

INSURANCE COMPANY (PLAN) NAME _____

POLICY/SUBSCRIBER/ID NO. _____

GROUP NO. _____

EMPLOYER/UNION NAME (IF GROUP COVERAGE) _____

INSURED'S SOCIAL SECURITY NO. _____

ANY INFORMATION YOU FEEL WOULD HELP US AS WE CONTACT THE INSURANCE PLAN

_____

_____

IF NO INSURANCE COVERAGE, PLEASE INDICATE HERE _____

_____ _____
Parent Signature Date

-See Over-

_____
Student Name

SECONDARY INSURANCE PLAN

INSURED'S NAME _____

INSURANCE COMPANY (PLAN) NAME _____

POLICY/SUBSCRIBER/ID NO. _____

GROUP NO. _____

EMPLOYER/UNION NAME (IF GROUP COVERAGE) _____

INSURED'S SOCIAL SECURITY NO. _____

WISCONSIN MEDICAL ASSISTANCE PROGRAM
(Also known as Title XIX/Medicaid/Medical Assistance)

Was the student certified by Medical Assistance within the past year? Yes No

Is your child eligible for Medical Assistance this month?
Yes No

If not, when did eligibility end? _____

Student's 10-digit Medical Assistance identification number _____

NOTE: Please let us know if your circumstances change; for example, if there is a change in insurance carriers, or if the student becomes Medical Assistance certified at some future point or loses Medical Assistance eligibility.

114

APPENDIX H

Illustration of Forms

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. #

1 PROCESSING TYPE

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

5 DATE OF BIRTH

6 SEX M ☐ F ☐

8 BILLING PROVIDER TELEPHONE NUMBER ( )

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE

9 BILLING PROVIDER NO.

10 DX: PRIMARY

11 DX: SECONDARY

12 START DATE OF SOI:

13 FIRST DATE RX

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 OR	20 CHARGES
					TOTAL CHARGE	21

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 _____ DATE

24 _____ REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE _____ EXPIRATION DATE _____

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

_____ DATE

_____ CONSULTANT/ANALYST SIGNATURE

482-120

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/SOIA

PRIOR AUTHORIZATION SPELL OF ILLNESS ATTACHMENT

(Physical, Occupational, Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS	(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) THERAPIST'S TELEPHONE NUMBER
		( )

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. ☐ Physical Therapy SOI ☐ Occupational Therapy SOI ☐ Speech Therapy SOI

B. Provide a description of the recipient's diagnosis and problems. Indicate the functional regression which has occurred and the potential to reachieve the previous skill level.

C. Attach a copy of the recipient's Therapy Plan of Care, including a current evaluation.

D. What is the anticipated end date of the spell of illness?

E. Supply the physician's dated signature on either the Therapy Plan of Care or the Physician's Order Sheet.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

F. _____ Signature of Prescribing Physician (A copy of the Physician's Order Sheet is acceptable) _____ Date

G. _____ Signature of Therapist Providing Evaluation/Treatment _____ Date

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/TA

THERAPY ATTACHMENT

(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME

(2) FIRST NAME

(3) MIDDLE INITIAL

(4) MEDICAL ASSISTANCE ID NUMBER

(5) AGE

PROVIDER INFORMATION

(6) THERAPIST'S NAME AND CREDENTIALS

(7) THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER

(8) ( ) THERAPIST'S TELEPHONE NUMBER

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested _____

Total Sessions per week requested _____

Total number of weeks requested _____

C. Provide a description of the recipient's diagnosis and problems including date of onset.

F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation)

G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:

H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).

I. Rehabilitation Potential:

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

J. _____
Signature of Prescribing Physician
(A copy of the Physician's order sheet is acceptable)

_____
Date

_____
Signature of Therapist Providing Treatment

_____
Date

ICN - DO NOT WRITE IN THIS SPACE

HEALTHCHECK (EPSDT) SERVICES

WISCONSIN MEDICAL ASSISTANCE PROGRAM
EDS FEDERAL CORP 6406 BRIDGE RD MADISON WI 53784

1 NAME OF PROVIDER | 2 PROVIDER NUMBER

3 ADDRESS OF PROVIDER | PHONE

4 NAME OF PATIENT (LAST FIRST MIDDLE) | 5 PATIENT S I D NUMBER

6 ADDRESS OF PATIENT | 7 PRIMARY PHYSICIAN ☐ NONE

8 DATE OF BIRTH / / | 9 PARENT OR GUARDIAN | 10 DENTIST ☐ NONE

11 SEX (Check One) ☐ M ☐ F

12 RACE ☐ WHITE ☐ BLACK ☐ INDIAN ☐ HISPANIC ☐ ORIENTAL ☐ OTHER ☐ UNKNOWN

13 PATIENT PHONE

14 DATE OF SCREEN / /

COMMENTS

15 A PROCEDURE CODE	B TYPE OF TEST		C REF CODE	D CHARGE
	BASIC SCREENING PACKAGE	EP		
	HEALTH HISTORY	H1		
	VISION	V1		
	HEARING	A1		
	HEIGHT/WEIGHT	E1		
	HEAD CIRCUMFERENCE	E2		
	PHYSICAL ASSESSMENT	E3		
	BLOOD PRESSURE	E4		
	DEVELOPMENTAL	E5		
	ORAL ASSESSMENT	E6		
	NUTRITIONAL EVALUATION	E7		
	OUTREACH CASE MANAGEMENT	C2		
	E P	D6		
	HEMATOCRIT _____ %	D4		
	HEMAGLOBIN _____ g	D5		
	MANTOUX	D7		
	SICKLE DEX	D9		
	PELVIC EXAM	D0		
	PAP SMEAR	D1		
	URINALYSIS	D3		
	A DO AGE AND HEALTH HISTORY INDICATE A NEED FOR IMMUNIZATION AT THIS VISIT? CHECK YES OR NO	YES ☐ 08	NO ☐ 01	
	B IF ANSWER TO A WAS YES, WAS IMMUNIZATION FOR AGE AND HEALTH HISTORY COMPLETED AT THIS VISIT? CHECK YES OR NO	☐ 08	☐ 13	
	DTP	S1		
	Td	S2		
	ORAL POLIO	S3		
	MEASLES	S4		
	RUBELLA	S5		
	MUMPS	S6		
	MR	S7		
	MMR	S8		
	Hb Pv	S9		
	17 TOTAL CHARGES			

16 A REF CODE	B REFERRAL PROVIDER NAME AND/OR SPECIALTY AND TYPE	C REFERRAL PROVIDER NUMBER	D DATE OF APPT (If By Scrn)

REFERRAL CODES

00 Test not Accep	05 Eye Specialist	10 Education	16 Family Planning
01 Not Referred	06 Oth Med Spec	11 Mental Health	17 Prenatal Care
02 Ret from Under Treatment	07 Social Serv	12 Bureau of Crippled Children	18 Red Cross
03 Physician	08 Immunized on See	14 WIC Program Nutritionist	
04 Dentist	09 Public Health	15 Hearing Specialist	

I AGREE TO THE CERTIFICATION ON REVERSE SIDE

18 SIGNATURE OF SCREENER / / DATE

DISTRIBUTION
COPY 1 to EDS FEDERAL
COPY 2 to REFERRAL PROVIDE
COPY 3 to SCREENER
COPY 4 to PATIENT

492-024
FORM AUTHORIZED UNDER HSS 106 03 (01)

BEST COPY AVAILABLE

CERTIFICATION

I hereby certify that the charges submitted hereon are my (our) usual and customary charges for the services rendered or items furnished, and I agree to accept payment of that sum or the usual, customary and reasonable charges for similar services by others in the community, whichever is the lesser. I further certify that no supplemental charges have been or will be billed to the patient (except for sums, if any, which represent charges for non-covered services under the Medical Assistance Program). I agree to abide by the policies and procedures as stated in the informational material which has been available to me. Services, supplies, and other items billed for hereon are hereby certified as medically necessary for the diagnosis or treatment of the condition of the patient.

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the States Title XIX Plan and to furnish information regarding any payments claimed for providing such services as the state agency may request.

The State Department of Health and Social Services operates under the provisions of Title VI of the Civil Rights Act of 1964. Under the provisions of this act any provider of services receiving Federal Funds must comply with the intent of this act, and this means there shall be no discrimination because of Race, Color or National Origin. This title also provides for a strict compliance and complaint procedures.

I.C.N. (DO NOT WRITE IN THIS SPACE)

E.D.S. FEDERAL CORP.
6406 BRIDGE ROAD
MADISON, WI 53784

DRUG CLAIM FORM

RECIPIENT INFORMATION

BILLING INFORMATION

1									$
2									$
3									$
4									$
5									$

CERTIFICATION

I CERTIFY THE SERVICES AND ITEMS FOR WHICH REIMBURSEMENT IS CLAIMED ON THIS CLAIM FORM WERE PROVIDED TO THE ABOVE NAMED RECIPIENT PURSUANT TO THE PRESCRIPTION OF A LICENSED PHYSICIAN. FORMATTED OR DETAILED CHARGES ON THIS CLAIM FORM DO NOT EXCEED MY USUAL AND CUSTOMARY CHARGE FOR THE SAME SERVICES OR ITEMS. WHEN REQUIRED BY FEDERAL OR FEDERALLY FUNDED STATE AGENCY POLICIES WHICH IMPLEMENT THE MEDICAID ASSISTANCE PROGRAM, I UNDERSTAND THAT ANY PAYMENT MADE IN SATISFACTION OF THIS CLAIM WILL BE DERIVED FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAW.

PHARMACIST'S OR
PRESCRIBING PHYSICIAN'S
SIGNATURE _____ DATE _____

PRIOR AUTHORIZATION NUMBER

O.T.	
TOTAL CHARGES	$
OTHER AMOUNT	$
NET BILLED	$

BEST COPY AVAILABLE

APPROVED OMB NO. 0938-0279

1	2	3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
	5 BC/BS PROV. NO.	6 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9

10 PATIENT'S LAST NAME | FIRST NAME | INITIAL | 11 PATIENT'S ADDRESS | CITY | STATE | ZIP

12 BIRTH DATE	13 SEX	14 M/S	ADMISSION 15 DATE	16 HR.	17 TYPE	18 SRC	19 A.M.	20 D.H.	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV. D.	24 N.C.D.	25 C.T.D.	26 L.R.D.	27

28 CD	DATE	29 OCCURRENCE CD	DATE	CD	DATE	31 OCCURRENCE CD	DATE	CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34

CONDITION CODES 35	36	37	38	BLOOD RECORD (PINTS) 40 PURN	41 REPL	42 NOT RP	43 DED.	44 SP. PROG.	45

46 VALUE CD	AMT	CD	AMT	48 VALUE CD	AMT	CD	AMT
a							
b							

50 DESCRIPTION	51 H.CFA	52 S. UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 REL INFO	59 BEN	60 DEDUCTIBLE	61 COINSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A							
B							
C							

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P REL	68 CERT. SSN HIC ID NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A					
B					
C					

71 R/D	72 ESC.	73 EMPLOYER NAME	74 EMPLOYEE ID.	75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PHYS. CODE	OTHER DIAGNOSES CODES 78	79	80	81

82 P.C.	83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE CD	DATE	CD	DATE	86 OTHER PROCEDURE CD	DATE

PSRO UR DATA 87 CD	88 APP FROM	89 APP THROUGH	90 GRC	91 TREATMENT AUTH.	92 ATTENDING PHYSICIAN ID.	93 OTHER PHYSICIAN ID.

94 REMARKS

VETERANS N.C. STAY DATES FROM	THROUGH	FOR INTERMEDIARY USE ONLY PR. PSC. D.		

AMT. REIMBURSED	N PYM CD			APPROV. BY	DATE APPROV.

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X 96 DATE

UB-82 HCFA-1450

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APPENDIX I

Instructions for HCFA 1500

HEALTH INSURANCE CLAIM FORM

FORM APPROVED OMB NO 0938-0008

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

☐ MEDICARE (MEDICARE NO.) ☐ MEDICAID (MEDICAID NO.) ☐ CHAMPUS (SPONSOR'S SSN) ☐ CHAMPVA (VA FILE NO.) ☐ FECA BLACK LUNG (SSN) ☐ OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2 PATIENT'S DATE OF BIRTH

3 INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4 PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO

5 PATIENT'S SEX: MALE ☐ FEMALE ☐

6 INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE. INCLUDE ALL LETTERS)

7 PATIENT'S RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8 INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9 OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10 WAS CONDITION RELATED TO:

A PATIENT'S EMPLOYMENT: YES ☐ NO ☐

B ACCIDENT: AUTO ☐ OTHER ☐

11 INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO

11 a CHAMPUS SPONSOR'S

STATUS: ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED — BRANCH OF SERVICE

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW

SIGNED DATE

13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15 DATE FIRST CONSULTED YOU FOR THIS CONDITION

16 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16 a IF EMERGENCY CHECK HERE ☐

17 DATE PATIENT ABLE TO RETURN TO WORK

18 DATES OF TOTAL DISABILITY: FROM THROUGH

DATES OF PARTIAL DISABILITY: FROM THROUGH

19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED DISCHARGED

21 NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

23 A DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS (1, 2, 3, ETC. OR DX CODE)

1
2
3
4

B

EPSDT YES ☐ NO ☐

FAMILY PLANNING YES ☐ NO ☐

PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM TO	B * PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * TOS	H LEAVE BLANK

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

DATE

26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐

27 TOTAL CHARGE

28 AMOUNT PAID

29 BALANCE DUE

30 YOUR SOCIAL SECURITY NO

31 PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO

32 YOUR PATIENT'S ACCOUNT NO

33 YOUR EMPLOYER I.D. NO

I.D. NO

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS

AC 306 (3/89)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (1-84) Form CHAMPUS-501 Form OWCP-1500 Form RRB-1500

BEST COPY AVAILABLE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAM.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured"; i.e., items 3, 6, 7, 8, 9 and 11.

BLACK LUNG AND FECA CLAIMS: The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered a 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION.

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

- 1 - (IH) - Inpatient Hospital
- 2 - (OH) - Outpatient Hospital
- 3 - (O) - Doctor's Office
- 4 - (H) - Patient's Home
- 5 - - Day Care Facility (PSY)
- 6 - - Night Care Facility (PSY)
- 7 - (NH) - Nursing Home
- 8 - (SNF) - Skilled Nursing Facility
- 9 - - Ambulance
- 0 - (OL) - Other Locations
- A - (IL) - Independent Laboratory
- B - (ASC) - Ambulatory Surgical Center
- C - (RTC) - Residential Treatment Center
- D - (STF) - Specialized Treatment Facility
- E - (COR) - Comprehensive Outpatient Rehabilitation Facility
- F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 - Medical Care
- 2 - Surgery
- 3 - Consultation
- 4 - Diagnostic X-Ray
- 5 - Diagnostic Laboratory
- 6 - Radiation Therapy
- 7 - Anesthesia
- 8 - Assistance at Surgery
- 9 - Other Medical Service
- 0 - Blood or Packed Red Cells
- A - Used DME
- F - Ambulatory Surgical Center
- H - Hospice
- L - Renal Supplies in the Home
- M - Alternate Payment for Maintenance Dialysis
- N - Kidney Donor
- V - Pneumococcal Vaccine
- Y - Second Opinion on Elective Surgery
- Z - Third Opinion on Elective Surgery

BEST COPY AVAILABLE

HCFA 1500 CLAIM FORM COMPLETION

Following are sample illustrations and descriptions of how to complete a HCFA 1500 claim form for occupational therapy services for private plans and WMAP. Remember, WMAP has service type specific directions, so consult the applicable handbook.

Private Plan

Program Block--Mark the box labeled "other" and type the name of the insurance company and mailing address in the blank space above the phrase "Health Insurance Claim Form."

Item 1 - Enter full name of the student in the noted sequence.

Item 2 - Enter student's birthdate in this format (06 01 84 for June 1, 1984)

Item 3 - Enter the full name of the insured in the indicated sequence. If the insured and student are the same person, type "same".

Item 4 - Enter mailing address, area code and phone number of the student.

Item 5 - Mark only one box.

Item 6 - Enter insured's ID number (sometimes referred to as certificate number), if group plan; most often his/her social security number. If individual plan, enter policy number.

Item 7 - Mark only one box. If the student is the insured, check "self".

Item 8 - Enter insurance plan group number, if known. The box in this item relates only to claimants age 65 or older.

Item 9 - Enter information about other insurance plan(s), if reported by the student's family.

Item 10 - Mark only one box in A and B. Check no if the diagnosis (condition) reported on this claim form is completely unrelated to the student's employment or accident related.

Item 11 - Enter mailing address, area code and phone number of the insured, if different than that noted in Item 4; otherwise, type "same".

Item 11a - Leave blank.

Item 12 - Enter "signature on file," if you have a current consent for release of medical information from the student's family.

Item 13 - Enter "signature on file," if you have a current assignment of benefits declaration from the insured.

Item 14 - Leave blank.

Item 15 - Leave blank.

Item 16 - Leave blank.

Item 16a - Mark this box only if services are related to an emergency or life-threatening medical condition.

Item 17 - Leave blank.

Item 18 - Leave blank.

Item 19 - Leave blank or enter IEP, or prescribing physician.

Item 20 - Leave blank.

Item 21 - Enter the applicable site (e.g., Langtree Hospital), if the services were rendered at a site other than on school district premises.

Item 22 - Mark the box labeled "no."

Item 23A - Enter ICD-9CM codes for all related conditions or symptoms; list the primary diagnosis first.

Item 23B - Leave blank.

Item 24A - Enter the date of the procedure in this format (03 06 90 for March 6, 1990). You can enter a series of dates in this format (03 09 90, 03 10 90) if:

- All dates of service are in the same calendar month in consecutive days.
- All procedures were identical and performed by the same provider.
- Place and type of service are identical for all procedures.
- Number of services performed on each date are identical.
- Charges for each procedure are identical.

Item 24B - Enter 0 if services were rendered by a provider employed by the school district or if services were rendered on school district premises by a contractee provider. Otherwise, choose the most appropriate code (e.g., 2 for outpatient hospital).

Item 24C - On the first line, enter a general description of the claim services (e.g., occupational therapy services). Enter the CPT-4 code number and matching description that best describes the services provided. The description should be a concise abstract of the applicable narrative found in the CPT-4 code book. Next to the description, enter the total minutes (e.g., 60 minutes). Beneath the description of service, enter the name/credentials of the "performing" provider (e.g., Sue Miller, O.T.R.)

Item 24D - Enter the ICD-9-CM from Item 23A that relates to the noted procedure. Either enter in the actual code number or enter, for example, 1 if the applicable ICD-9-CM is listed first in Item 23A.

Item 24E - Enter the total charge for each line item. If there were a series of dates noted in Item 24A, then the number of services entered in Item 24F must divide equally into the amount of the total charges on this line.

Item 24F - Enter frequency/number of services billed for each line item. A number higher than 1 would be used if:

- The procedure was performed more than once on any given day or,
- Inclusive dates were entered in Item 24A,

  Note: A modality/procedure unit of service for therapy is each 15 minute segment.

Item 24G - Enter one code per line from the list on the back of the HCFA-1500 form. A LEA would most likely use TOS #1.

Item 24H - Leave blank.

Item 25 - A signature and date must appear on all manually-generated claims. This signature may be written by the provider, his/her authorized representative or stamped with a facsimile signature stamp authorized by the provider. On computer generated claim forms, no signature is required, but the name of the authorized representative should be noted.

Item 26 - Leave blank.

Item 27 - Enter the total of the charges from Item 24E.

Item 28 - Enter the amount paid by the prime insurance carrier, if the claim now being generated is to a secondary carrier; otherwise, leave blank.

Item 29 - Enter the difference between the totals of Items 27 and 28.

Item 30 - Leave blank.

Item 31 - Enter the name, address, city, state, zip code, area code and phone number of your school district.

Item 32 - Optional.

Item 33 - Enter your school district's employer ID number.

Wisconsin Medical Assistance Program

Program Block - Enter the appropriate Claim Sort Indicator for the service billed in the Medicaid check box in the upper lefthand corner of the claim form. The indicator codes can be found in the WMAP provider-specific bulletins. The letter 'T' is the indicator for Therapy - occupational, physical, speech and hearing.

Item 1 - Enter full name of the student in the noted sequence.

Item 2 - Enter student's birthdate in this format (06 01 84 for June 1, 1984)

Item 3 - Enter "same" if the student is the person who is the insured or policy holder; otherwise, leave blank.

Item 4 - Enter mailing address, area code and phone number of the student.

Item 5 - Mark only one box.

Item 6 - Enter the student's ten digit WMAP ID number.

Item 7 - Leave blank.

Item 8 - Leave blank.

Item 9 - Enter one of these codes (OI-P, OI-D, OI-C, OI-S, OI-R, OI-E, OI-A, OI-H), if the student is covered by private insurance and if the service(s) on this claim are one of those identified as "Services Requiring Third-Party Billing" and/or "Services Requiring Third-Party Billing Dependent on the Type of Health Insurance Coverage" as defined and explained in Section IX-D and Appendix 18 of the WMAP Provider Handbook, Part A.

Item 10 - Mark only one box in A and B. Check no if the diagnosis (condition) reported on this claim form is completely unrelated to the student's employment or accident related.

Item 11 - This element is used by WMAP for Medicare information. For those rare circumstances is which the student is eligible for Medicare Part B, refer to Section A9-006a and Appendix 17 of the WMAP Provider Handbook, Part A for an explanation of the process of "crossover claims"

Item 11a - Leave blank.

Item 12 - Leave blank.

Item 13 - Leave blank.

Item 14 - Leave blank.

Item 15 - Leave blank.

Item 16 - Leave blank.

Item 16a - Mark this box only if services are related to an emergency or life-threatening medical condition.

Item 17 - Leave blank.

Item 18 - Leave blank.

Item 19 - Enter IEP.

Item 20 - Leave blank.

Item 21 - Enter the applicable site (e.g., Langtree Hospital), if the services were rendered at a site other than on school district premises.

Item 22 - Mark the box labeled "no."

Item 23A - Enter ICD-9CM codes for all related conditions or symptoms; list the primary diagnosis first.

Item 23B - Check the box labeled "NO" for EPSDT, unless the services claimed were provided as a result of a HealthCheck referral rather than through the IEP process. Under those circumstances, check the box labeled "YES" for EPSDT and enter the HealthCheck prior authorization number. Check the box labeled "NO" for family planning services, unless such services were rendered; if so, check the box labeled "YES."

If there is a WMAP prior authorization in place covering the services claimed, then enter the seven digit prior authorization number from the approved PA/SOIA form. Services authorized under multiple prior authorizations must be billed on separate claims.

Item 24A - Same as for private plan except there can only be a maximum of four dates of service per line.

Item 24B - Enter 0 if services were rendered by a provider employed by the school district or if services were rendered on school district premises by a contractee provider. Otherwise, choose the most appropriate code (e.g., 2 for outpatient hospital).

Item 24C - Enter the "performing" provider's eight digit WMAP provider number in addition to all that entered on a private insurance claim.

Item 24D - Enter the ICD-9-CM from Item 23A that relates to the noted procedure. Either enter in the actual code number of enter, for example, 1 if the applicable ICD-9-CM is listed first in Item 23A.

Item 24E - Enter the total charge for each line item. If there were a series of dates noted in Item 24A, then the number of services entered in Item 24F must divide equally into the amount of the total charges on this line.

Item 24F - Same as for private plan except that WMAP considers a unit of services as 30 minutes, rather than 15 minutes.

Item 24G - Enter one code per line from the list on the back of the HCFA-1500 form. A LEA would most likely use TOS #1.

Item 24H - Leave blank.

Item 25 - A signature and date must appear on all manually-generated claims. This signature may be written by the provider, his/her authorized representative or stamped with a facsimile signature stamp authorized by the provider. On computer generated claim forms, no signature is required, but the name of the authorized representative should be noted.

Item 26 - Leave blank.

Item 27 - Enter the total of the charges from Item 24E.

Item 28 - Enter either $0.00 or the amount paid by other insurance.

Item 29 - Enter the difference between the totals of Items 27 and 28.

Item 30 - Leave blank.

Item 31 - Enter the school district's eight digit WMAP group billing number, in addition to all that would be entered on a private plan claim.

Item 32 - Optional.

Item 33 - Enter your school district's employer ID number.

APPENDIX J

Third-Party Claim Offices

HEALTH INSURANCE CARRIERS IN WISCONSIN

Aetna Life & Casualty
P.O. Box 26279
Milwaukee, WI 53226
(414) 256-2200

Alta Health Strategies, Inc.
P.O. Box 26199
Milwaukee, WI 53226
(414) 774-7760
(800) 242-9613

American Family Insurance
P.O. Box 7430
Madison, WI 53791-9940
(608) 249-2111

American Medical Security
P.O. Box 19032
Green Bay, WI 54307-9032
(800) 333-5534

Association Life
P.O. Box 2976
Milwaukee, WI 53201
(414) 797-5000

Bankers Life & Casualty
4444 West Lawrence Avenue
Chicago, IL 60630
(312) 777-7000

Benefit Administrators of America
P.O. Box 9120
Des Moines, IA 50306
(515) 243-3210

Benefit Plan Administrators
P.O. Box 1128
Eau Claire, WI 54702
(715) 832-5535

Benefit Trust Life
P.O. Box 7903
400 Field Drive
Lake Forest, IL 60045
(708) 234-8700
(800) 227-0687

Blue Cross & Blue Shield of Minnesota
P.O. Box 64338
St. Paul, MN 55164
(612) 456-8000

Blue Cross - Blue Shield United of Wisconsin
Claims Office
P.O. Box 2063
Milwaukee, WI 53201
Correspondence
1515 River Center Drive
Milwaukee, WI 53212
(414) 224-6195
(800) 242-9605

Blue Cross - Blue Shield United of Wisconsin
Claims Office
P.O. Box 3060
Milwaukee, WI 53201
Correspondence
19 West Main Street
Evansville, WI 53536
(800) 362-5459

Blue Cross - Blue Shield United of Wisconsin
Claims Office
P.O. Box 3057
Milwaukee, WI 53201
Correspondence
145 South Pioneer Road
Fond du Lac, WI 54935
(800) 722-2132

Blue Cross - Blue Shield United of Wisconsin
Claims Office
P.O. Box 3029
Milwaukee, WI 53201
Correspondence
2270 Highland Center
Eau Claire, WI 54701
(800) 621-4560

Note: Blue Cross also has separate "Preferred Service" units for select major groups

Central Life Assurance of Wisconsin, Inc.
P.O. Box 5912
Madison, WI 53705
(608) 238-5841

Claim Management Services
P.O. Box 10888
Green Bay, WI 54307-0888
(414) 497-1589

Claim Management Services
1043 South Main Street
West Bend, WI 53095
(414) 338-9889

Employee Benefit Claims
P.O. Box 884
Appleton, WI 54912
(414) 731-5333

Employee Benefit Claims
P.O. Box 17200
Milwaukee, WI 53217
(414) 962-1766

Employee Benefit Plans
435 Ford Road, Suite 500
Minneapolis, MN 55426
(612) 546-8117

Employers Health
Green Bay, WI 54344
(414) 336-1100

Employers Insurance of Wausau
GBHPP Claims Department
P.O. Box 8013
Wausau, WI 54402-8013
(800) 472-0041

Employers Insurance of Wausau
Certi Claims Department
P.O. Box 8012
Wausau, WI 54402-8012
(800) 472-0041

Equicor
P.O. Box 10485
Des Moines, IA 50306
(515) 223-9600

Federal Life Insurance Company
3750 West Deerfield Road
Riverwoods, IL 60015
(708) 520-1900

Federated Mutual Insurance Company
Pentagon Office Park
4570 West 77th Street, Suite 330
Minneapolis, MN 55435
(800) 328-9291

Golden Rule Insurance
Golden Rule Building
712 11th Street
Lawrenceville, IL 62439
(618) 943-8000

Great West Life Assurance Company
230 West Monroe Street, Suite 200
Chicago, IL 60606
(800) 621-7226

Health Benefit Plan, Inc.
P.O. Box 1139
Kenosha, WI 53141
(414) 657-3193

John Hancock
International Center, Suite 290
900 2nd Avenue South
Minneapolis, MN 55402
(612) 339-8595

John Hancock
P.O. Box 4005
Schaumburg, IL 60168-4005
(708) 706-4050

Lincoln National Life
P.O. Box 2249
Fort Wayne, IN 46801
(800) 248-0811

Metropolitan Life
615 East Michigan
Milwaukee, WI 53202
(414) 271-0410

Mid America Mutual
1801 West County Road B
Roseville, MN 55113
(612) 631-1075

Ministers Life
P.O. Box 910
Minneapolis, MN 55440
(612) 927-7131

National Benefit Consultants
P.O. Box 19035
Green Bay, WI 54307-9035
(414) 496-2500

NWNL Health Management Corp.
(Northwestern National Life)
Atrium Building, Suite 220
1295 Bandana Blvd. N.
St. Paul, MN 55108
(612) 647-0558

Principal Financial Group
2514 South 102nd Street
Lincoln Center, Suite 300
West Allis, WI 53227
(414) 327-3279

Provident Life Insurance
25 Merchant Street, Suite 100
Cincinnati, OH 45246-3732
(513) 552-7000

Prudential Insurance
P.O. Box 9478 (Large Groups)
Minneapolis, MN 55440
(612) 349-2179

Prudential Insurance
P.O. Box 9403 (Small Groups)
Minneapolis, MN 55440
(612) 553-6111

Rural Security Life Insurance
P.O. Box 5555
Madison, WI 53705
(608) 833-8080

Sentry Insurance
P.O. Box 8888
Stevens Point, WI 54481
(800) 426-7234

Time Insurance Company
515 West Wells
P.O. Box 624
Milwaukee, WI 53201
(414) 271-3011

Travelers Insurance
P.O. Box 1200 (Railroad Claims)
Lansing, IL 60438
(800) 842-5252

Travelers Insurance
One Prairie Center
Matteson, IL 60443
(708) 747-9400

Uniformed Services Benefit Plans, Inc.
c/o The Associated Group
P.O. Box 3055 (Initial Claims Submission)
P.O. Box 3070 (Followup Claims Inquiry)
Columbus, IN 47202
(800) 842-4333

WEA Insurance Trust (WEAIT)
45 Nob Hill Road
P.O. Box 7338
Madison, WI 53707-7338
(608) 276-4000
(800) 279-4000

WELS Benefit Plan
2949 North Mayfair Road, Suite 116
Milwaukee, WI 53222-4392
(414) 771-4460
(800) 545-4141

Wisconsin Area Health Fund
1314 North Stoughton Road
Madison, WI 53714
(608) 244-4280

Wisconsin Health Insurance Risk Sharing Plan (HIRSP)
OGCPC Unit
Mutual of Omaha
Mutual of Omaha Plaza
Omaha, NB 68172
(800) 877-1060

Wisconsin Laborers Health Fund
621 North Sherman Avenue
Madison, WI 53704
(608) 249-6457

Wisconsin Physicians Service
1717 West Broadway
P.O. Box 8190
Madison, WI 53708
(608) 221-4711
(414) 359-1220 (City of Milwaukee Group)
(414) 359-1313 (County of Milwaukee Group)

W.A.T.D.A. Insurance Trust
(Wisconsin Automobile & Truck Dealers Association)
P.O. Box 5345
Madison, WI 53705
(608) 251-5577

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APPENDIX K

Explanation of Benefits

BENEFIT TRUST LIFE INSURANCE COMPANY
P. O. BOX 7903, LAKE FOREST, ILLINOIS 60045-7903

EXPLANATION OF BENEFITS

PEDIATRICS S.C.

WI

THIS IS NOT A BILL

EXPLANATION OF BENEFITS

NAME/ID

CLAIM FOR

COMPANY OR GROUP
CORPORATION

CLAIM NO.

GROUP NO.

DATE: 10/26/90

PATIENT NO:

DATES OF SERVICE-PROVIDER/SERVICE	AMOUNT CHARGED	AMOUNT INELIGIBLE	DISCOUNT	AMOUNT COVERED	ENCOUNTER FEE	DEDUCTIBLE	COINSURANCE	BENEFIT	CODES
	1	2	3	4=1-2-3	5	6	7	8=4-5-6-7	**
10/01-10/01/90: PEDIATRICS DIAGNOSTIC LAB FEES	18.00	0.00	0.00	18.00	0.00	18.00	0.00	0.00	
EXPLANATION OF CODES TOTALS	18.00	0.00	0.00	18.00	0.00	18.00	0.00	0.00	

** ITEMS 2, 5, 6 & 7 MAY BE BILLED TO PATIENT

OTHER COVERAGE	0.00
ADJUSTMENTS	0.00
AMOUNT OF PAYMENT	0.00

PEDIATRICS S.C.

WI

CHECK DISTRIBUTION

TOTAL 0.00

00452-00452 D-H

WELS VEBA GROUP HEALTH PLAN 2949 North Mayfair Road, #116 • Milwaukee, WI 53222-4392

EXPLANATION OF BENEFITS

THIS EXPLANATION OF BENEFITS SUMMARIZES THE CLAIM PROCESSED FOR [ ]
11/27/90. PAYMENTS TOTALING $751.60 WERE ISSUED AS FOLLOWS:

PAYEE	AMOUNT	CHECK NO.
M.D.	45.60	
	706.00	

BENEFITS WERE CALCULATED IN THE FOLLOWING MANNER:

PROVIDER / SERVICE	FROM	THROUGH	TOTAL EXPENSE	DENIED EXPENSE	EXP CODE (If CODE Present See Reverse For an Explanation)	DEDUCT. APPLIED	OTHER INSURER	BENEFIT
., M.D.								
OFFICE VISITS	09/13/90		5700					4560
MEDICAL SUPPLY	03/21/90		28350					22680
MEDICAL SUPPLY	05/26/90		29950					23960
MEDICAL SUPPLY	09/06/90		29950					23960
** TOTALS **			93950					75160

A TOTAL OF $ 200.00 HAS BEEN APPLIED TOWARD YOUR 1990 INDIVIDUAL DEDUCTIBLE.
A TOTAL OF $ 400.00 HAS BEEN APPLIED TOWARD YOUR 1990 FAMILY DEDUCTIBLE.

IF YOU HAVE ANY QUESTIONS ABOUT THIS CLAIM PLEASE CONTACT:

SHERYL 800-545-4141 EXT 294 OR (414)771-4460

WELS VEBA GROUP HEALTH PLAN 2949 NORTH MAYFAIR ROAD, #116 MILWAUKEE, WI 53222-4392

COMPANY NAME
WELS VEBA GROUP HEALTH PLAN

PARTICIPANT

IDENTIFICATION NO. CLAIM NO.

COMPANY NO. PLAN NO. DIVISION NO.

RURAL SECURITY LIFE INSURANCE COMPANY
P.O. Box 5555, Madison, Wisconsin 53705-0555

Date: 04/12/89 Plan Number:
Plan Name:

Member Name Claim Number
Member ID

Patient and Relationship Patient Account Number Examiner ID

Patient has met of the 19 Deductible

Patient has met of the 19 Out of Pocket

Provider	*	Date of Service	Charges Submitted	Excluded Amount	** BASIC. ST - DOLLAR	Deductible	%	MAJOR MEDICAL	Total Benefit
	OT	02/02-02/20/89	207.00	0.00	0.00	0.00	80	207.00	165.60
	PT	02/02-02/23/89	155.00	0.00	0.00	0.00	80	155.00	124.00
		Totals ▶		0.00	0.00	0.00		362.00	289.60

*Type of Service
Code Description

OT OCCUPATION THERAPY
PT PHYSICAL THERAPY

Total Charges Submitted	362.00
Total Payment Amount	289.60
Paid to Member	0.00
Paid to Provider(s)	289.60
Non-covered	0.00
Paid by Other Carrier	0.00
Adjustments	0.00

**Remarks
Code Description

XCF01 (11-88) 24097M

-161-

WPS

WISCONSIN PHYSICIANS SERVICE

1717 West Broadway • P.O. BOX 8190 • Madison, Wisconsin 53708 (608) 221-4711

PROVIDER EXPLANATION OF BENEFITS

THIS EXPLANATION OF BENEFITS IS INTENDED TO PROVIDE A BETTER UNDERSTANDING OF OUR RESPONSIBILITY FOR CHARGES INCURRED.

MEM HOSP

PO BOX 37

WI

PAGE 1

PLACE OF SERVICE	TYPE OF SERVICE
1 - OFFICE 2 - HOME 3 - INPATIENT HOSPITAL 4 - EXTENDED CARE FACILITY 5 - INPATIENT MENTAL HOSPITAL 6 - OUTPATIENT HOSPITAL 7 - OUTPATIENT PSYCHIATRIC/PSYCHIATRIC 8 - SPECIALTY HOSPITAL 9 - OTHER	1 - MEDICAL SERVICES 2 - SURGICAL 3 - CONSULTATION 4 - DIAGNOSTIC X-RAY 5 - DIAGNOSTIC LABORATORY 6 - RADIATION THERAPY 7 - ANESTHESIA 8 - ASSISTANCE AT SURGERY 9 - OTHER D - DENTAL L - DENTAL - ORAL SURGERY M - PSYCHIATRIC P - NURSING SERVICES R - AMBULANCE SERVICES V - VISION CARE W - APPLIANCE & EQUIPMENT X - MATERNITY Y - PRENATAL THERAPY Z - NEWBORN

PATIENT'S NAME SUB. NUMBER	DATE OF SERVICE		NO. OF SERVICES	AMOUNT BILLED	WPS ALLOWANCE	SEE BELOW	APPLIED DEDUCTIBLE				WPS PAYMENT	SEE BELOW	PATIENT'S ACCOUNT NUMBER
	05/29/90	5 Y	000	180.00							144.00	DC	
CLAIM #	TOTAL			180.00							144.00		

TOTAL WPS PAYMENT ON 07/06/90 $144.00

THE SUBSCRIBER'S POLICY HAS A COINSURANCE PROVISION WHICH IS HIS OR HER RESPONSIBILITY.

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RESOURCES

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Bureau for Children with Physical Needs
Department of Public Instruction
125 South Webster Street
Madison, WI 53702
(608) 266-3886

Bureau for Exceptional Children
Department of Public Instruction
125 South Webster Street
Madison, WI 53702
(608) 266-1781

Bureau of Health Care Financing
Department of Health and Social Services
1 West Wilson, Room 250
Madison, WI 53701-0309
(608) 266-2522

Bureau of Long Term Support
Department of Health and Social Services
1 West Wilson, Room 472
Madison, WI 53702
(608) 267-7284

Bureau for Pupil Services
Department of Public Instruction
125 South Webster Street
Madison, WI 53702
(608) 266-8960

Bureau for School Management Services and Federal Aids
Department of Public Instruction
125 South Webster Street
Madison, WI 53702
(608) 267-7475

Bureau for State School Aids Administration and Consultation
Department of Public Instruction
125 South Webster Street
Madison, WI 53702
(608) 266-2840

Department of Coding and Nomenclature
American Medical Association
535 North Dearborn Street
Chicago, IL 60610
(312) 464-5000

Document Sales and Distribution
Department of Administration
P.O. Box 7840
Madison, WI 53707
(608) 266-3358

E.D.S Federal Corporation
6406 Bridge Road
Madison, WI 53784
(608) 221-4746

Office of the Commissioner of Insurance
121 East Wilson
Madison, WI 53702
(608) 266-3585